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THE MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. I.—3RD YEAR—NO. 2. SYDNEY: SATURDAY, JANUARY 8, 1916. PRICE 6D.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—3RD YEAR. SYDNEY: JANUARY 8, 1916. No. 2.

A FATAL CASE OF ERYTHEMA PAPULATUM.

By **Alfred Austin Lendon, M.D. (Lond.)**,
Adelaide.

Previous History.

The patient was a married woman of 52 living in the country; her menses had ceased two years previously, although there were still traces of the climacteric. She had borne two children, one of whom had died of tubercular meningitis at the age of seven years. Her mother was alleged to have had rheumatism at the time of the patient's birth; a grandfather is said to have been gouty. In 1890 she had lumbago during a whole month, suffering acutely for one week, and in December, 1892, she had another attack, which lasted about four months, but was less severe in character. In 1896 she consulted Dr. J. C. Verco at his rooms, and was under his observation for over three weeks. Her illness commenced with a sore throat on March 15th. On the 23rd she had *erythema nodosum*, with severe pains in, and stiffness of, the left elbow and the right thumb, and with a phlyctenula of the left eye. She remained in bed for ten days, and nodes were still visible on April 16th. In 1903 she first consulted me on account of indigestion and anæmia There was no cardiac murmur. A few days later she had some muscular rheumatism. In October, 1904, she came to me with lumbago and sciatica of a few weeks' standing. She remained after this in good health till early in 1914, when she had fluid in both knees. This condition lasted for a couple of months and then cleared up.

Onset of the Present Illness.

In October, 1914, she came to me again. There was now "rheumatism," principally in the upper limbs, and involving not only the joints, from the shoulders to the fingers, but also the nerves, and affecting the lower limbs slightly. The results of treatment were not striking, and in November she took the opportunity of being in Melbourne to consult Dr. David Grant, who considered that she had rheumatoid arthritis, and advised a certain course of treatment, which was persevered in for some months after her return to Adelaide in December; it included sea-salt foments, massage, ionization, Tallermann baths, etc. Although she always believed herself to be better for the treatment, the progress was slow and her condition variable. The net result was that the lower limbs improved a great deal, the left arm became practically well, but the right shoulder was firmly ankylosed. About the 8th of April, 1915, a bout of dyspepsia set in, and some tiny red spots were noticed on the fingers, but no importance was attached to them. Treatment was again unsatisfactory, in spite of discontinuing the rheumatic drugs, which it was thought might have disagreed with her. There was occasionally some slight elevation of temperature at night time. On May 4th there seemed to be a relapse of rheumatism, which she attributed partly to the weather which ushered in the breaking up of the drought, and partly to discontinuing her anti-rheumatic medicines. The patient also had some slight conjunctivitis at this time. Treatment of the rheumatism again seemed to induce dyspepsia, and Dr. de Crespigny, who was consulted, suggested trying a vaccine, but from the gums no culture could be obtained. Some red papules were noticed at this time on the neck and on the side of the right cheek, in front of the ear, whilst those on the fingers were yet in evidence, but they seemed of small importance as compared with the rheumatism. The patient returned home for a week, and on May 24th came back to town so ill that she was at once sent into a private hospital, where she remained till her death on July 6th.

The Eruption.

She had a rash fully developed on the face; it was roughly symmetrical. The constituent elements were discrete, papular, erythematous spots, but on the ears the rash was confluent. The lobes were universally inflamed and swollen, with a thin, dried, scabby secretion, and the inflammation was continued on the cheeks, in front of the ears, and to the neck, behind. On the nose, the distribution of the rash was not unlike that of *acne rosacea*; on the forehead and among the roots of the hair it was ordinary *erythema papulatum*; about the eyelids and nostrils and lips there was more the appearance of a vesicular eruption. The conjunctivæ showed well-marked lesions, such as we are familiar with in nodal fever (*erythema nodosum*), *viz.*, "phlyctenules" on the ocular conjunctivæ, over the insertions of the tendons of the muscles, and inflamed flat patches on the lower palpebral edge; on the skin of the upper eyelids were small, hæmorrhagic, bruised patches (*erythema contusiforme*). On the fingers and toes and balls of the feet there were red, papular spots and minute hæmorrhages. The latter were also noticed, especially under the nails, where they were arranged as striæ. The lips, mouth, tongue and throat were simultaneously affected, but here the lesions took the form of red patches, which speedily became superficial ulcerations, and caused very great distress in feeding, and thus interfered greatly with her capacity for taking nourishment.

Course of the Disease.

The patient vomited occasionally. At times she was light-headed, and on June 3rd a cough was noticed. The joint troubles, meanwhile, seemed to be in abeyance, at all events they were over-shadowed by the erythema and the accompanying toxæmia. There was still a great deal of indigestion, and the bowels were constipated. No headache was complained of, nor were shivers mentioned. The temperature was persistently raised, save when a dose of aspirin was given, which always brought it down.

It ranged usually between 101° and 103°, the highest point reached being 103.6°. The pulse-rate was usually only about 80, and the respirations 22 per minute. The urine contained albumin throughout, but no casts were found. Owing to her sleeplessness, sulphonal was given at night, and soothing applications were prescribed for the rash and for the mouth. On June 4th, when the rash was at its height, she was seen by Dr. J. C. Verco. During the first half of the month of June, the temperature seldom exceeded 101°, although on the 8th there were well marked signs of pneumonia at the left base. On the 16th, the condition, both general and local as regards the eruption, was much improved, although the pneumonic signs had not cleared up. At 2 p.m. on that day a rigor occurred, and the temperature reached 104.4°. The patient then complained of pain along the left forearm, and there was discovered some swelling, with tenderness on pressure, over the middle third of the radial side; the feet were found to be swollen also, and tender on pressure about the ankles and some of the smaller joints. Dr. Verco saw her again with me on June 22nd, and suggested that pneumococcal periostitis and arthritis might explain this new development. However, these signs gradually subsided, though the patient did not improve in herself. A large, lumbar pad of œdema was noticed, and a slight bedsore commenced about this time. Meanwhile, the face and mouth were steadily improving day by day, and by the 24th were quite well, though the hæmorrhagic spots were still visible on the toes and the fingers. For a couple of days (25th-26th) we were quite hopeful of her recovery, but, after that date, she gradually became worse. The signs in the chest and the cough persisted, though, with a quite inconsiderable amount of expectoration, which did not contain any tubercle bacilli. The respirations remained at about 30 till July 1st, and there was neither dyspnœa nor great rapidity of the heart's action till then. After that date, the delirium became more constant, the fever higher, and signs of general weakness increased. She gradually sank, and died on July 6th, at 7 p.m.

Remarks.

I think that there are two points that require to be established at the outset, *viz.*, (1) the correctness of the diagnosis of *erythema papulatum*, and (2) the assumption that death was due to this disease.

As regards the diagnosis, I am personally quite satisfied, and am, moreover, fortified by the opinion of Dr. J. C. Verco. I know the difficulty of portraying a word picture of any skin eruption, and I admit that in some respects this description of *erythema papulatum* differs slightly from that of certain authors, who seem to lay more stress on the eruptions which appear on the fingers and hands. However, I have called it by the name which is attached to the most prevalent type of eruption, though possibly it might be more correct to dub it *erythema multiforme*, for there were, in addition to the papules, lesions which were macular, vesicular, and hæmorrhagic, though there was nothing in the shape of *erythema nodosum* or *erythema iris*. Again, did my patient die of *erythema papulatum*? In my opinion, undoubtedly she did. The only complication of the erythema was the patch of pneumonia, but she certainly did not succumb to that, and, although it is true that the physical signs had not actually cleared up, still at no time was it a dominant feature of the case, and, when the pneumonia was at its height, the temperature was lower than formerly, and the patient rather better. From the moment of the establishment of the erythema, the arthritic troubles seemed to be quite in abeyance. But, seeing that the eruption on the face was on the wane at the time when the patient herself was steadily going down hill, can it be maintained that she died of *erythema papulatum*? A patient suffering from typhoid fever may die of accidents, such as perforation of intestine or of hæmorrhage, or may succumb to the toxæmia of the *B. typhosus*; in either case, the death is due to typhoid. Our patient died of gradual exhaustion from the toxæmia of the erythema rather than from the accident of pneumonia.

Admitting then that the patient had *erythema papulatum*, and that she died of it, a further question of interest arises. What relationship does it bear to other skin eruptions, such as *erythema multiforme*, and to nodal fever (*erythema nodosum*), which we do not usually look upon as diseases involving any serious risk to life? Now this is no new question, and it is interesting to cast a glance at the views that have prevailed in the past.

In 1847, Erasmus Wilson, who was then the High Priest of Dermatology, considered that *erythema papulatum*, *erythema tuberculatum* and *erythema nodosum* were so closely allied that, if it were not for the fear of creating confusion, he should include them under the same name.

In the 'sixties the lectures of Trousseau, one of the greatest masters of clinical teaching of the last century, were published and translated by the New Sydenham Society. Of these lectures, one is devoted to the consideration of *erythema papulatum*, and an account is given of three cases. In one, the disease rapidly proved fatal; in another, the patient's life was in jeopardy for more than fifteen days; whilst the third patient, at the end of sixty days' illness, was as weak as if he had had an aggravated attack of typhoid fever, or as Trousseau called it, *dothinenteria*. He further mentions that *erythema papulatum* is accompanied by serious pulmonary lesions. Professor Trousseau, in another lecture, differentiates *erythema nodosum* from all other forms of erythema, and states that it is a "specific and separate disease"; and, in dealing with *erythema papulatum* he is at some pains to contrast it with *erythema nodosum*, and he alleges that the former is a much more serious complaint. At the same time he allows that he has never seen *erythema nodosum* unaccompanied by *erythema papulatum*, whilst he admits that the above mentioned three cases of *erythema papulatum* exhibited undoubted *erythema nodosum* on their legs. M. Hardy (of Paris) about the same time also gave a good account of *erythema papulatum*, the prognosis of which he considered a little more grave than that of this class generally.

In the next decade Tilbury Fox taught that there was a gradation between *erythema papulatum*, *erythema tuberculatum* and *erythema nodosum*, and that the last was a more marked stage of the others. Balmanno Squire also said that *erythema papulatum* was only a smaller edition, as it were, of *erythema nodosum*.

Jameson in the 'eighties on the other hand, wrote that *erythema papulatum* and *erythema tuberculatum* might exist independently or simultaneously, but that they were not mere stages of progression.

Ziemssen (1885) said that *erythema papulatum* and *erythema tuberculatum* were only part of *erythema multiforme*.

Duhring (1898) distinguishes between *erythema multiforme* and *erythema nodosum*, but he does not isolate *erythema papulatum*. He notes that they both sometimes affect the mouth and throat.

Malcolm Morris (1908) says *erythema papulatum* is part of *erythema multiforme*, whilst Gaucher (1910) sees three forms, *erythema papulatum*, *erythema tuberculatum* and *erythema nodosum*, which may co-exist in the same patient.

Now, I have given these few illustrations of the widely divergent views that have been held with respect to *erythema papulatum* and its relationship to *erythema nodosum* on the one hand, and to *erythema multiforme* on the other, but there can be no doubt, however, that the general belief now is that all three are closely related. From my own observations, detailed at more length elsewhere, I consider that these varieties are more than related, and, with Erasmus Wilson, I believe that they are one and the same disease; and, though we may see an instance of an almost pure culture, if I may so describe it, of *erythema nodosum* in one patient, and of *erythema papulatum* in another case, still many of the cases, such as the one I have narrated, show such varied multiple lesions, nodular, papular, macular and vesicular, that the term *erythema multiforme* might more properly be applied to them. In my case of *erythema papulatum*, there is further the interesting fact that nearly twenty years ago the patient suffered from a well-defined attack of nodal fever (*erythema nodosum*), accompanied by its characteristic arthritic pains and phlyctenula, and preceded by a sore throat.

Another question immediately suggests itself; assuming that *erythema papulatum* and *erythema nodosum* are merely varieties, or phases, of one common disease, call it *erythema multiforme* if you will, what relationship does this group of diseases bear to other definite complaints, such as acute rheumatism or tuberculosis. My own contention is that we have here an acute specific disease, *sui generis*, with a multiform eruption that may be confined solely to the skin in some cases, that may be seen in addition on mucous membranes such as the conjunctiva frequently, that may affect the mouth and air passages, and even the lungs occasionally, and that may be presumed from the symptoms to attack the synovial and teno-synovial membranes also. That this group of diseases is not "rheumatic" in nature, as was originally taught by Sir Stephen Mackenzie with reference to *erythema nodosum* (a doctrine which has been handed down for some decades without much questioning or re-investigation), I have also endeavoured to show, though I readily admit that I have seen nodal fever in patients with obvious evidence of "rheumatism" past or present, just as in the patient whose case is the subject of my theme. Gaucher points out that the majority of contemporary authors regard *erythema papulatum* as an infective disease, and the concomitant joint affection as pseudo-rheumatic. He argues that the researches of Haushalter with a micrococcus are inconclusive. But rheumatism, he adds, is also thought to be microbic; therefore, it is necessary to prove that the pathogenic agent of *erythema multiforme* is not identical with that of rheumatism. Writing in 1907, Dr. Odery Symes, of Bristol, inclined to my view that *erythema nodosum* was an acute specific disorder, and drew attention to the marked difference in the arthritis, which accompanies it, from that of acute rheumatism.

With respect to the variety described as *erythema papulatum*, the same desire to attribute it to a manifestation of the rheumatic diathesis has not been so evident, and, therefore, there is not the same necessity to combat the suggestion; it would be merely beating the air.

Another disease has come upon the scene of late years, and has claimed a share in the pathology of these erythemata. Writing ten years ago, I said somewhat flippantly, in endeavouring to discount the evidence of the supposed association of *erythema nodosum* with rheumatism, that I thought "it would be just as easy to prove, so far as mere statistics are concerned, that the disease is related to tuberculosis." My evidence merely amounted to this. Dealing with 44 cases of nodal fever, distributed among 34 families, I knew nothing of the family history in nine of the families, but I knew it was good in another nine families, whilst in sixteen there was something amiss, and, of these, five showed well pronounced tubercular taint. None of the patients had tubercular antecedents, but two died of phthisis. Very shortly afterwards my attention was drawn to an article making a similar suggestion in a German publication, and quite recently, Dr. Odery Symes has written further on the subject. Durante, of Naples, 1912, on the other hand, argues that, because some patients afterwards develope tubercle, this fact does not make *erythema nodosum* a manifestation of tuberculosis. Although what relates to *erythema nodosum* has, in my opinion, a bearing upon *erythema papulatum*, I do not wish to discuss this point at present, but merely to draw attention to the fact that my patient's child succumbed to tubercular meningitis.

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THE CASE FOR CREMATION.[1]

By **E. V. Stevens,**
Honorary Secretary, The Brisbane Cremation Association.

On behalf of the Brisbane Cremation Association, I have to express our thanks for the opportunity you have afforded us to place our views before you.

We realize that, apart from the strenuous life led by your members, the times are momentous, and our thoughts are centred on events that loom largely before us.

When things again return to normal, we believe that the importance of our objective will be recognized, and our progress rapid. For the time being, we are content to make what headway we can, and to embrace every opportunity to disseminate as widely as possible such information on the subject as we have.

This seems to me a most appropriate date upon which to discuss the subject of cremation. On this night there is a widespread wave of cremation in effigy, at least, of a personage celebrated in English history.

It has, however, been suggested that the medical profession are more keenly interested in life than in death. This view I hope to be superficial, as the dead, we contend, exercise an important influence upon the health of the living.

We live in an age that, despite its progress, is still conservative, especially in matters of faith and sentiment, and I propose to deal briefly with the three important points upon which objections, more or less logical, are raised against cremation.

These points are:—

(1) The religious.
(2) The sentimental.
(3) The precautionary.

I do not intend dealing at any length with the religious objection. Though we believe that this objection has no foundation in fact, we realize that it is a matter of individual privacy, and that interference is not only unwarranted, but unwise.

We content ourselves with the declaration that there is nothing in the practice of cremation contrary to an intelligent and reverential acceptance of Christian faith. High dignitaries of the Church have publicly expressed their approval of it, and many of them have been cremated. Neither have we any desire to enforce cremation upon objectors; our needs for the present will be met if an opportunity for those who believe in it is afforded us.

Sentiment.

Sentiment plays a very important part in the conduct of life, and is worthy of a greater degree of cultivation than is at present expended upon it. At the same time it is essential that our sentiment should be based upon an intelligent and reasoning understanding of the source of it.

That sentiment which conforms to the outward sign and neglects or ignores the inward grace should be held to scorn as a conventional sham. In all changes of radical nature this spurious sentiment is a strong factor to contend against. So ingrained has it become that it is impervious to reason or argument.

The sentiment that finds gratification in the thought of a loved one laid to rest on the bosom of Mother Earth, as it is poetically termed, and cannot or will not compare the disgusting putrefactive processes through which the body passes in earth burial with the rapid, cleanly action of cremation, is either hopelessly bound in conservatism or ignorant of the process of cremation.

The most natural and sanitary method of disposing of a body, failing cremation, would be to expose it as far as possible to the factors of disintegration—sun, rain, and wind. Cremation accelerates the reduction of the body to its component elements, earth burial retards it.

Sentiment, however, is a small factor when opposed to the utilitarian demands of the age. Should public necessity demand it, the last relics of mortality are ruthlessly disturbed with pick and shovel, and carelessly reburied, while sentiment utters not a protest.

What room exists for sentiment when death itself has been commercialized? Sentiment is measured by display, by the ostentation of the funeral, and the vulgarity of the memorial stone.

The crematoria of England have been designed on lines of architectural beauty, the grounds artistically laid out, and the whole effect is one of peace and reverence, while columbaria and urn lend themselves to æsthetic considerations to a greater degree than memorial stones and coffins.

Sentiment, too, is shocked by a prevalent but mistaken idea that cremation of the body means burning it. Nothing could be further from the fact. In a modern crematorium no flame comes in contact with the body, which is subjected to an intense heat, some 1500° Fahrenheit, causing rapid dessication. After about one hour, nothing remains but a little white ash.

Protection Against Crime.

This is a phase of our subject upon which considerable doubt exists; as it is highly important, it is desirable that it be subjected to the severest scrutiny and criticism.

We agree that the process of cremation should be so safeguarded as to render it impossible to conceal crime by such means, and we assert that the Cremation Act of Queensland, in common with all Acts governing the process in other countries, fulfils that requirement.

Under the Queensland Act, it is provided that no cremation can take place without a permit issued by the Registrar, who shall:—

(1) Require certificates from two legally qualified medical practitioners, one of whom must have been in professional attendance

[1] Read at a Meeting of the Queensland Branch of the British Medical Association on November 5, 1915.

upon the deceased, and both certificates stating that the deceased died from natural causes; or

(2) Certificate by *post mortem*; or

(3) Certificate by inquiry or inquest.

The Attorney-General or any of his agents may forbid the cremation of any body, either absolutely or until the removal of any organs of the body has been made.

It is a cause of complaint with the English Cremation Association that while stringent precautions are taken in the case of cremation, nothing is done to remedy the laxity of the law relating to earth burial. The great contrast in precaution operates against cremation and seriously impedes its progress.

In a paper read by Dr. J. C. McWalter, of Dublin, before the Forensic Medicine Section of the International Congress of Medicine, the doctor stated that he had in his time signed considerably over 1,000 death certificates, but not in 2% of the cases did he see the dead body, and not in 10% did he visit the patients; the majority of them called at his surgery. In all these cases there were not more than ten autopsies, and in most cases where an autopsy was performed, his diagnosis had proved to be wrong.

We may, I think, assume that Dr. McWalter is a reputable practitioner, and that his actions are strictly in accordance with the requirements of English law; presumably also his experience is not unique. Could cremation offer greater facilities for the concealment of crime?

The Registration Act of Queensland, passed in 1855, prior to Separation, is evidently thought to be such a model of perfection that no amendment of it has been found necessary. New South Wales, working under the same Act, was so dissatisfied with it, that, in 1899, it was repealed, and their Acts on this matter consolidated.

A death in Queensland need not be registered for 30 days, and the medical certificate, while demanding from the medical attendant the cause of death, does not require him to certify that he actually saw the person at death, or viewed the body prior to burial. It is sufficient if he certifies that he is informed that the death has occurred.

There are cemeteries that are subject to no law, as far as I can discover; they will accept for burial bodies for which no medical or other certificate of death has been obtained. In country districts burial without certification is of common occurrence. Despite the inadequacy of the Act regulating earth burial, the objection to cremation that it offers a means of concealment of crime persists in some quarters. No greater facilities in this respect could be offered than those at present existing. The Registration Act of Queensland is essentially a statistical Act.

Economic.

The importance of the case for cremation from the economic standpoint has not, I think, been sufficiently emphasized. Crematoria require a very small area of land, as compared with cemeteries for earth burial, and they are not likely to become overcrowded.

The main areas held as cemetery reserves in and around Brisbane are as follows:—

	Acres.
Toowong	255
South Brisbane	22
Balmoral	51
Mount Gravatt	700

The Balmoral Cemetery will serve as an illustration of the economic deadweight the community has to carry. This cemetery being in the vicinity of my residence, I am enabled to speak with some knowledge of local values. As is usual, the pick of the land has been reserved for the cemetery. After allowing six acres for roads, there would remain 45 acres = 450 sixteen perch allotments. Settlement in the locality during the last two years has been very rapid, and, taking the local land values at £30 per allotment, £13,500 worth of land is rendered non-productive to the extent, according to local taxation, of approximately £300 per annum in rates alone.

Not only is the local authority deprived of this revenue, but the presence of the cemetery has a depreciating effect upon land values in its vicinity.

The same would apply, with probably greater force in the case of South Brisbane and Toowong, while the reservation of 700 acres at Mount Gravatt, at an estimated cost of £4,000, of which £2,000 has already been advanced by Government, is an outrage upon one of the few exceptionally fine beauty spots surrounding the city.

There are no cemeteries, nor will there ever be cemeteries so far removed from centres of population as to be extra-mural for all time.

One of the early burial grounds of Brisbane, the Paddington Cemetery, was, at the time of its reservation, doubtless regarded as being outside the future spread of population.

The earliest interments in this cemetery appear to have been made in 1844; in 1875, just 31 years after, owing to the growth of population in the vicinity, the cemetery was closed.

During the interval 1875 to 1910, the various religious bodies to whom sections of this cemetery had been granted in trust failed so utterly in their reverence of *God's acre* and those reposing therein, that the cemetery became an eyesore.

The trusts were terminated and the land vested in Government nominees for purposes of public utility.

The cost to Government for renovation, re-interment, etc., amounted to £3,038.

For seventy years this land remained totally unproductive.

The removal and re-interment of remains from the Devonshire Street Cemetery, Sydney cost the Government of New South Wales £50,000; sufficient to have erected ten crematoria, which would have served the State's needs for all time.

Sanitary.

It is upon this ground that we hope to obtain a large measure of support from the medical profession. There is no section of the community more capable

of thoroughly realizing the danger to the living resultant on the indiscriminate burial of the dead.

In Australia, happily, there is considerable immunity from plagues and virulent diseases, but there is no guarantee that our freedom in this respect will maintain, and no effort should be spared to combat diseases that extension of trade with less favoured countries will inevitably introduce sooner or later.

These seems little doubt that the vitality of disease germs is not impaired by even lengthy periods of inhumation. The late Lord Lister, it is stated, traced a virulent outbreak of septic fever in the Glasgow Surgical Hospital to the fact that the hospital had actually been built over a long-forgotten burial ground. Upon excavation, a multitude of coffins were discovered, which had been buried there during the cholera epidemic of 1849, the uppermost tiers being only a few inches below the surface. Numerous like cases could be quoted did time permit. These are happenings in older countries, where population is dense, but Australia is not without like occurrence.

Dr. Ashburton Thompson, Chief Inspector to the New South Wales Board of Health, reported on the contamination of a well, which formed the water supply of a dairy that proved the source of infection in an outbreak of typhoid fever.

Dr. J. M. Creed says:—[1] "Disgusting as such water is, however, sewage is not the only organic matter it contains. On both ridges are cemeteries, that to the west being the Balmain cemetery, which has been established about 16 years, and which now holds about 9,000 bodies; that on the east being the Balmain Roman Catholic cemetery, established about 12 years, and holding about 1,000 bodies. The soil was supposed to be impermeable until about November last, when the Corporation cut Norton Street down three feet, a shallow section of the lowest part of the cemetery was thus made, and I am told by many people that so fœtid a soakage flowed from the face to the street as rendered the latter almost impassable for nearly six weeks. . . . A clay soil delays putrefaction, but it happens in time, and, as is thus proved, when the coffins begin to leak, the putrilage is no longer confined to the grave, but enters the sub-soil water. With this it flows under Norton Street and down the slope to Helsarmel Creek, 240 yards away, where it meets a similar drainage from the Roman Catholic cemetery on the opposite ridge, and both together come to light again at last in that unconsecrated cauldron, the dairy well."

Now let us get nearer home. The Balmoral Cemetery, like all others, is situated in land of high elevation. The subsoil is stiff and clayey, retarding, but not preventing, percolation. At the foot of the cemetery is a succession of waterholes and gullies, from which, when water is present, the milking cows of at least one dairy drink. This may be quite harmless, but, to the lay mind, it is at least disturbing.

At Toowong a somewhat similar condition prevails, and I await only a favourable opportunity to test the accuracy of information given me in regard to drainage from this cemetery. Should my information be correct, I think the people of that favoured locality will hardly regard the cemetery with the same complacency that now exists.

The city of Cairns, till very recently, depended upon wells for its water supply. The subsoil is sandy and spewey, all graves have to be shored up as dug, and coffins well weighted to ensure anchorage, despite which, in the rainy season, coffins have been known to rise practically to the surface. Local geographical conditions are such that the drainage from the cemetery must, in part, find its way to the wells of the town supply, and the fact that Cairns has not been visited with an epidemic seems to argue more for good luck than good sanitation. How many isolated cases of illness have been traceable to this cause it is impossible to say, for seldom until disease becomes epidemic is action taken to locate the source of infection.

I believe I am right in saying that an offensive odour is not necessarily in itself harmful, but there seems to be a peculiar something in the exhalations from a decaying corpse that the living are peculiarly susceptible to. In Cairns, when the pipe-laying gang were cutting a trench close to the cemetery, the men were made violently ill by the effluvia arising. Dr. Creed, of Sydney, mentions a case coming under his observation of a boy who became very ill, and in a few days died after inhaling the smell from a disinterred corpse. More could be said, but sufficient evidence has, I think, been adduced, to show that earth burial is, at least, open to grave suspicion that would not exist were cremation made compulsory in cases of death from communicable diseases.

Under the Health Act, power is given the health authorities to claim for burial the body of any person who has died of plague, cholera or small-pox. Such bodies are buried with special precautions.

The British crematoria number thirteen, according to the latest available returns, and are as follows:

Woking, the pioneer crematorium, was completed in 1879, but the Home Secretary then in office forbade the practice, and the crematory was unused for some years. In 1884 Mr. Justice Stephens held that it was not an offence to burn a dead body, and the Cremation Society of England publicly offered the use of their crematorium at Woking, the first cremation taking place the following year. Since that time (1885), over 3000 cremations have taken place. The fees for cremation, including use of chapel, are £5.

Golders Green, opened 1902; fees, £4 4s. to £5 5s.
Manchester, opened 1892; fees, £2 2s. to £5 5s.
Liverpool, opened 1891; fees, £2 2s. to £5 5s.
Glasgow, opened 1895; fees, £2 2s. to £6 6s.
Hull, opened 1892; fees, £1 1s. to £3 3s.
Darlington, opened 1890; fees, £2 2s. to £5 5s.
Leicester, opened 1902; fees, £2 2s. to £5 5s.
Birmingham, opened 1903; fees, £5 5s.
Ilford, opened 1904; fees, £2 15s. 6d.
Leeds, opened 1905; fees, £4 4s. to £5 5s.
Bradford, opened 1905; fees, £3 3s. to £5 5s.
Sheffield, opened ——; fees, £2 2s. to £4 4s.

[1] Modern Cremation, by the Hon. J. M. Creed, M.L.C., etc., Sydney.

Australasia.

Adelaide.—Taken over from the Cremation Society by the State Government in 1903.

Cost.—Furnace	£500	
Duty, Freight, etc.	200	
Building and all Expenses	1,050	
		£1,750

Sydney.—A Cremation Society has been in existence since 1908. Successive Governments have promised grants for the erection of a crematorium, but failed to fulfil their promises. A prospectus for the formation of a company, with a capital of £5,000, has been issued, but held in abeyance pending promised action by the present Government.

Wellington, New Zealand.—The cost of the crematory has been £1,433, of which £863 was raised by public subscription, the balance being paid from the corporation funds. Seventy-seven cremations have taken place. Fees for cremation: £2 12s. 6d. to £4 4s.

Reports of Cases.

COLLAPSE AFTER ANTI-TETANIC SERUM INJECTION.[1]

By **Capt. C. L. Chapman, A.A.M.C.,**
No. 5 Australian Field Ambulance, Gallipoli.

Pte. T., æt. 22, reported on October 19, 1915, to the No. 5 Field Ambulance for a prophylactic dose of anti-tetanic serum, having been wounded slightly in the head the evening before. The patient was quite well, and apparently very healthy, rather stout and powerful, and there were no signs of degeneracy. A dose of 1500 units was injected with due precaution under the skin internal to left scapula. The needle puncture was dressed; the patient put on his clothes and decided to leave about five minutes afterwards. He had only gone about five yards when he had a sudden attack of dyspnœia, followed immediately by vomiting. He was put on a stretcher and artificial respiration quickly applied by Sylvester's method. A gag was inserted, as patient had a violent spasm of the jaw. The throat was perfectly clear, the pulse failed almost immediately, and, despite the application of hot bottles, injection of strychnine (gr. $^1/_{15}$), coffee ¾ pint by rectum, he showed no sign of recovery. No adrenalin was available at the time. After 25 minutes, artificial respiration was discontinued.

A post mortem examination was made.

External Appearances.—Healthy man, no enlarged glands, stellate wound in the left frontal region, no hæmorrhage, body generally blue, as in asphyxia. When the scalp was reflected the wound was found to extend to the pericranium. The skull was intact.

Internal Organs.—The meninges were a little injected, but there was no hæmorrhage. The brain was slightly congested, but otherwise normal. There was no ventricular hæmorrhage.

Thorax.—The thymus was not enlarged. The lungs and pleuræ were healthy; the lungs floated. The heart was normal in size, all the valves were normal. No clots were found, either in the heart or in the vessels. The mediastinal glands were not enlarged.

Abdomen.—No abnormality was detected. The spleen and mesenteric glands were normal. The bowel was not opened up.

The serum used was contained in a phial from the same package as was used quite successfully in other cases. No information is available as to whether he had had any injection of this or any other serum previously. It is known that he had not had a serum injection for the last four months. There was no record of epileptic and no evidence of previous fits. In the face of the facts, it would appear that this was one of those cases showing extreme intolerance to the presence of the foreign serum in the body.

[1] Published by Permission of Lt.-Col. Roth, D.S.O., V.D., C.O., No. 5 Field Ambulance.

Naval and Military.

In the London *Gazette*, dated December 30, 1915, the names of Major R. G. Finlayson, Captain F. R. Kerr and Captain S. F. McDonald are included in the list of those "recommended" for gallant and distinguished conduct in the field.

It is our painful duty to record yet another death among the medical practitioners serving with the troops. The news that Captain A. G. Miller, R.A.M.C., has been killed in action in France was received on January 3, 1916. Captain Albert Guy Miller was born in Melbourne, in 1884. He was educated at the Melbourne Grammar School, and studied medicine at the University. He graduated in 1909. After holding some resident posts at the Melbourne Hospital and elsewhere, he went to England and joined the R.A.M.C. early in the war. In September he was given a commission with the 1st Battalion of the Middlesex Regiment, and subsequently was promoted to the rank of Captain.

It has been announced in the Commonwealth Military Order that approval has been given to the formation of an Australian Venereal Diseases Hospital for service in Egypt. The staff will comprise an Officer Commanding, a Lieutenant-Colonel, two Majors, one of whom will be the official syphilologist and dermatologist, four Captains, one Quartermaster, one Warrant Officer, 11 Sergeants, 1 Bugler, 15 Corporals and 89 rank and file. The hospital will accommodate 1,040 patients.

In the District Order, No. 131, of the 2nd Military District, the following announcement appears:—

Issue of Medical Certificates.

In cases of injury or sickness incurred by a soldier on duty and attended by a Military Medical Officer in the course of his duty, a certificate will be furnished by the Medical Officer in charge of the case, when required by any Friendly or Insurance Societies, without further charge to the soldier.

Dr. Thomas Wren Faulkner has been appointed Medical Officer in Charge of the Royal Military College of Australia (temporarily) with Honorary Rank of Captain, A.A.M.C. Reserve, 2nd Military District, and salary at the rate of £500 per annum.

The following appointments have appeared in the *Commonwealth of Australia Gazette*, under date of December 23, 1915:—

Army Medical Corps.

To be Temporary Lieutenant-Colonel—
Major C. G. Shaw. Dated 6th September, 1915.

To be Captain—
Lieutenant H. I. Carlile. Dated 1st June, 1915.

To be Quartermaster and Honorary Lieutenant—
Warrant Officer Ronald Glen. Dated 11th September, 1915.

1st Military District.

Australian Army Medical Corps Reserve—
Robert August Meek to be Honorary Major. Dated December 10, 1915.
Roy Veseys Graham to be Honorary Captain. Dated December 10, 1915.

2nd Military District.

Australian Army Medical Corps—
William Bain Walton to be Captain (provisionally and temporarily). Dated 1st December, 1915.

The provisional appointments of Captains C. J. Wiley, F. H. Sabiel, W. Vickers, F. O. Stokes, and R. I. Furber are confirmed.

Captain H. H. Field-Martell is transferred to Australian Army Medical Corps, 3rd Military Dis-

trict, with seniority as from date of transfer. Dated 13th September, 1915.

Captain W. G. Armstrong is transferred from Australian Army Medical Corps Reserve, and to be Major. Dated 28th September, 1915.

Australian Army Medical Corps Reserve—

William Henry Coutie and Stewart Arthur Smith to be Honorary Majors. Dated 10th December, 1915.

John Colman Woods, William Sproule, George Williams Foster, John a'Beckett Darvall Barton, Allen Muscio, Edmund Rupert Roseby, Isaac Manly Barrow, and Ernest Noel Brougham Docker to be Honorary Captains. Dated 10th December, 1915.

Renfrew Frederick Maxwell Wray and Frank Francis Freeman to be Honorary Lieutenants. Dated 10th December, 1915.

Honorary Captains J. Booth-Clarkson and D. Smith to be Honorary Majors. Dated 10th December, 1915.

Honorary Lieutenant J. H. Bradley to be Honorary Captain. Dated 10th December, 1915.

3rd Military District.

Australian Army Medical Corps—

Captain H. H. Field-Martell is transferred from Australian Army Medical Corps, 2nd Military District, with seniority as from date of transfer. Dated 13th September, 1915.

Australian Army Medical Corps Reserve—

Honorary Captains J. F. Wilkinson and C. R. Player to be Honorary Majors. Dated 10th December, 1915.

Henry Fitzgerald Maudsley, John Kidd Collier Laing, Henry William James Cook, and Arthur Vincent Henderson to be Honorary Captains. Dated 10th December, 1915.

Llewellyn Jones to be Honorary Lieutenant. Dated 1st December, 1915.

Henry Arthur Leslie Lambert, Rolland Fraser, Donald McLellan Austin, Lancelot Arthur Freeman, and George Samuel Prout to be Honorary Lieutenants. Dated 10th December, 1915.

4th Military District.

Australian Army Medical Corps—

Honorary Captain C. L. Clarke is transferred from Australian Army Medical Corps Reserve, and to be Senior Medical Officer, Australian Imperial Force Camp, Mitcham, with temporary rank and pay of Major ,at rate prescribed by Universal Training Regulation 160. Dated 24th June, 1915. (This cancels the notification respecting this officer which appeared on page 1797 of *Commonwealth of Australia Gazette*, No. 108, of 11th September, 1915.)

Australian Army Medical Corps Reserve—

Joseph James Herman Engelbrecht, John Trotter Hardy, Charles Webb, William Frank Driscoll, John Whinham Hosking, Roy Lancelot Sims, Harold Crosland, Benjamin Thomson, Percival Ray Newling, Henry Creswell Doidge Taunton, and Frank Martin Swan to be Honorary Lieutenants. Dated 10th December, 1915.

5th Military District.

Australian Army Medical Corps Reserve—

Frank Merrett Wilkinson to be Honorary Captain. Dated 10th December, 1915.

6th Military District.

Australian Army Medical Corps Reserve—

Lindsay Stevens Miller and George Glendinning Watson to be Honorary Captains. Dated 10th December, 1915.

Clement Gordon Harris and John Graham to be Honorary Lieutenants. Dated 10th December, 1915.

Honorary Lieutenant H. B. Henley to be Honorary Captain. Dated 10th December, 1915.

THE NEW YEAR HONOURS.

Among the recipients of honours on the occasion of the New Year is one Australian medical practitioner, Sir Charles Kinnaird Mackellar, who has been created a K.C.M.G. Sir Charles has been so prominently before the public for many years that it appears to be almost superfluous to enumerate some of the more important of his achievements. In the medical world, Sir Charles Mackellar held the office of the President of the New South Wales Branch of the British Medical Association in 1883-1884. He was President of the Board of Health in 1883-1885, and adviser to the Government in matters of hygiene and public health. It was due to his energies and foresight that provision was made for isolating infective diseases in New South Wales. He instituted the Quarantine Station at North Head, and the Coast Hospital at Little Bay. His administration of the Board of Health was remarkable for the forethought of the measures adopted, and for the thoroughness with which all the enquiries into the conditions appertaining to health were undertaken. In connexion with the birth-rate, his actions have been of a pioneering type, and are recognized as such throughout the whole world. In 1886 he was given a seat in the Ministry as Minister for Mines. He was also a member of the Ministry under the Premiership of Jennings. During more recent years, he has been a member of the Senate. From 1901 to 1914 he was President of the State Children's Relief Board, and the masterly manner in which he organized and expanded this Department has served as a pattern in every country. In 1912 he was knighted. His association with the New South Wales Bank, of which he is President, has given him a position in financial and Governmental circles quite apart from his activities in hygiene or politics.

THE LEEUWINHOEK MEDAL.

The Leeuwinhoek Medal of the Dutch Academy of Science has been awarded to Surgeon-General Sir David Bruce, C.B., F.R.S., A.M.S., for his researches on trypanosomiasis and Malta fever. The medal is awarded every 10 years, and Sir David is the fourth recipient. Sir David Bruce was born in Melbourne in 1855. His work in the R.A.M.C. as Assistant Professor of Pathology at Netley as a member of the Army Medical Advisory Board and as a surgeon in the South African campaign, and his researches as Director of the Royal Society's Commissions for the investigation of sleeping sickness, of Mediterranean fever and of the diseases endemic in the Nyasaland among many other things have contributed to his world-wide reputation.

THE TOOWOOMBA GENERAL HOSPITAL.

The financial straits of the General Hospital, Toowoomba, have been of increasing seriousness during the past months. As a result of the large demands made on the public purse, many of the hospitals have suffered considerably. Notwithstanding the boast that the Government in each State is responsible for the major part of the funds required for hospitals, many of these institutions are suffering badly at present. The Committee of the Toowoomba General Hospital has to find an annual sum of £10,000. The immediate needs of the hospital necessitate the raising of £1,000, in order that the work of the district may be continued as heretofore. The hospital contains 96 beds, and last year 1,800 patients were treated in the wards. Under the existing circumstances, the money had to be obtained from private sources to tide the Committee over its difficulty. When things are at their worst, it is said that they soon begin to mend. They could not have been much worse when Mr. Pigott came forward with a most generous offer, and we are confident that they will now mend rapidly. The offer was worth £100, and the conditions were that three other similar contributions, as well as four of half the amount, should be forthcoming. With £600 to work on, Mr. Pigott felt assured that the public would subscribe the remaining £400 without loss of time. A special appeal is being issued, and we look for an immediate, satisfactory deliverance of the Committee from its difficulties.

The Medical Journal of Australia.

SATURDAY, JANUARY 8, 1916.

The Orthopædic Treatment of Wounded Soldiers.

In another column a correspondent makes an important proposal in regard to the after treatment and care of wounded soldiers. He points out that, under the existing conditions, it is impossible for the medical officers in charge of the wounded on their return to the Commonwealth to apply that form of orthopædic treatment which is required to save the functions of limbs gravely injured by bullets or other projectiles, and suggests that specially trained surgeons should be engaged for hospital ships, in order that this work might be undertaken under favourable conditions. In his opinion, the surgeons and assistants, including masseurs and masseuses, could easily be trained in Australia within a few months, and he throws out the proposal that a beginning should be made at once. The matter is no doubt one which may at a later date be brought within the scope of the business of the Federal Medical War Committee, and of the six State Medical War Committees, but before this can be done, it may be well to consider the various phases of the situation, and to ask surgeons and others interested in this matter to express in the correspondence column of this journal their deliberate views. The duties of the regimental medical officer are of such a nature that any attempt to initiate treatment with a view of restoring function to an injured limb is quite out of the question. If he can give aid in staving off a fatal issue in wounds, he has done well. At the base hospitals, the surgeons have quite enough to do to fight with death and its precursors, sepsis and hæmorrhage, and no thought could be given to repair during these early days. At the stationary hospitals, after the wounded have been saved from the ravages of gangrene and necrosis, a preliminary step might be taken toward repair, but, as a rule, at all events during the period of active engagements, the surgeons would have too little time to grapple with this task. The next step brings the wounded soldier into calmer waters. When he is discharged from the stationary hospital at the front, to return to Australia or to England, the urgency of the wounds has passed, and healing has already made considerable headway. Orthopædic surgeons might then take charge of these men, and, without undue haste or excessive precipitation, map out and inaugurate the plan of treatment suitable for each case. It might be held that the treatment should be started after the arrival of the men in Australia or England. While this matter is one which experts are best able to decide, it appears to us that no useful purpose would be gained by a delay of this kind. In the next place, it is desirable to ascertain which conditions are regarded as the most favourable for ultimate functional cure in the treatment of shattered limbs and paralysed muscles. It is assumed that no doubt can exist as to the necessity of providing the soldiers with that trained surgical skill which gives them the best chance of leading a useful life later on. If experts will express opinions, the correspondence could be summed up in a collating article, and the Department for Defence could be urged to adopt those measures which surgeons regard as most desirable.

THE MILK SUPPLY OF ADELAIDE.

There is no chapter in hygiene of greater importance than that dealing with the milk supply of a community. In a few cities in the world the supply is under the direct control of the local authority, but under usual conditions, milk is offered for sale by private firms and individuals, and is merely subjected to control in so far as adulteration is concerned. The question of a pure milk supply has exercised the people of Adelaide during the past few years, and in July, 1913, a Royal Commission began its labours by enquiring into the best means of improving the supply of the metropolis. The idea of holding this enquiry emanated from Dr. T. Borthwick, who has paid especial attention to the various aspects of the question. Unfortunately, the evidence was limited to the witnesses within the city itself. A great mass of information was obtained, and many views were expressed before the Commissioners. In the course of time, the Commissioners have weighed all the evidence given, and, as a result of their deliberations, a majority and various minority reports

have been drawn up and issued to the public. The enquiry was undertaken with a view of ascertaining which means should be adopted to ensure a plentiful, a good and a cheap supply of milk.

The Commissioners have come to the conclusion that the quantity of milk produced in the metropolitan county district is insufficient for the needs of the city, unless supplemented from the country. The disadvantages connected with the milk derived from country farms consist in the difficulty of keeping milk in good condition during long transit. The Commissioners are persuaded that commercial pasteurization is quite unreliable, and medical witnesses are stated to have opposed the use of pasteurized milk for infants. Further, the Commissioners have formed the opinion that the retail price of milk should not exceed 6d. per quart. A large number of other facts and opinions have been marshalled before the Commissioners. On their basis they recommend that country dairies, from which milk is sent to the city, should be placed under strict inspection, that cooling should be rendered compulsory; that transport and delivery should be carried out while the milk is under seal; that the conditions in transport should be governed by regulation; and that the distribution should be undertaken in a definite manner. They have considered whether the distribution should be undertaken by a co-operative company of dairymen, by a public company, or by an official body. They also recommend the institution of depôts for supplying milk for infants.

It is anticipated that the report of the Royal Commission will be carefully considered by the Government, and that after some debate in the Houses of Parliament, regulations under the Pure Food and Drug Act will be drawn up. There are certain points of vital importance to which attention should be called. The milk problem is not the same for every city. In the case of Adelaide, the comparatively small population, namely, 43,500, the proximity of pasture land and the fertile nature of the same, and the excellence of the stock of milch cows, stand on the one side, while the high temperature in the summer time, and the fact that the railways are owned by the State may be offered as distinct difficulties. The Railway Commissioners maintain that improved railway facilities could not be provided without an increased cost of transport. In a hot climate, it is more than ever necessary that refrigerator cars should be provided for the transport of milk from distant country districts to the city. If it be found essential that Adelaide be supplied from distant districts, the Railway Commissioners should be called upon to supply modern conveniences for the safe carriage of milk, without any increase in freight. But we are not convinced that any considerable quantities of milk need be obtained from great distances. The daily consumption of milk per person in large towns varies between 3½ ounces (London) and 19½ ounces (Munich). The average may be taken at one half pint. It therefore appears that Adelaide would require not more than 3,000 gallons of milk daily. To produce this relatively small quantity within a narrow radius of the city should not be a difficult matter. Veterinarians should be brought into association with hygienists in selecting a good milching strain of cows, in order that the quality of the milk and the quantity produced from each dairy may be improved. The regulations should prescribe clean milking, immediate cooling and cleanly handling. For infants and invalids, milk should be bottled in glass bottles, provided with patent, hermetic stoppers, and kept at a low temperature until delivered. It has been demonstrated that the reaction of milk shows distinct changes to acid after about 12 hours, when kept at about 40° C. The control of milk arriving in Adelaide for sale should be strict, and when any sample is found to be unsatisfactory, the whole supply from that dairy should be refused, until a satisfactory sample has been submitted. This method of control has sufficed in Carlsbad to keep the number of bacteria and the quantity of dirt within reasonable bounds. Perhaps the most practical control with which we are acquainted is that introduced in Malmö, in Sweden, in 1909. The control in London only extends to the question of adulteration and to the inclusion of tubercle bacilli. The same may be said of the milk of Glasgow. In both these monster cities milk is sold at 2d. per pint, while in Malmö ordinary milk is supplied to a population twice the size of Adelaide at 1d. per pint, and bottled infant's milk at 1½d. per pint. In Carlsbad.

where conditions are distinctly extravagant, as compared with Sweden, controlled milk is retailed at 3d. per pint. It should therefore be possible to produce a satisfactory milk, properly controlled by the local authority in Adelaide, in quantities sufficient for the whole population at 2d. to 2½d. per pint under ordinary conditions, and 3d. per pint when sealed in special glass bottles and kept cool until delivery. The high price of labour should not make any appreciable difference in the price of the milk, but some allowance has to be made on account of the fact that special care must be exercised in the cooling of milk immediately after it is withdrawn from the cow.

PNEUMONOCONIOSES.

The association of dust and pulmonary disease has been recognized since the days of Hippocrates, and dusty trades have been regarded as conducive to lung affections and early death in all countries, and from the earliest times. When the community notes an association of external conditions with increased morbidity, there is always a tendency for extending the deductions beyond those justified by observed facts. Consequently, it was popularly believed that all dusts were inimical to good health and long life, and that the greater the amount of dust liberated in any occupation, the higher would be the incidence and fatality from pulmonary diseases. Within recent years, the subject of occupational hygiene has occupied the attention of many careful observers and of competent legislators and *pari passu* with the enunciation of definite knowledge more or less efficient remedies have been introduced. Some extremely important facts have been demonstrated within the past four or five years in connexion with pulmonary tuberculosis, bronchitis and pneumonia in miners and workers in certain dusty occupations, and the industrial pneumonoconioses has formed the subject of the Milroy Lectures, delivered at the Royal College of Physicians of London, in 1915, by Dr. Edgar L. Collis.[1] This series of lectures gains in importance because a great deal of the work has been undertaken by the author himself. The story he has to tell may be briefly summarized as follows: Dust must be in a state of extremely fine division to effect an entrance into the alveoli; it must be insoluble to cause a reactive stimulus on the ciliated epithelium to favour its expulsion; and it must have certain chemical and physical properties before any damage can be done to the lungs or bronchial apparatus. It appears that pure coal dust is not associated with bronchitis, and the same may be said of plaster of Paris and of alabaster. It is further shown that the bronchitis mortality is higher among the general population than among the workers in cement. Similarly, the inhalation of dusts which leads to bronchitis leads to pneumonia, and some of the dusts which produce pneumonia are associated with a high tuberculosis mortality.

By far the most important question in this connexion is the cause of tuberculosis in pneumonoconiotic lungs. Dr. Collis has demonstrated that all dusts which contain crystalline silica are potentially causes of miner's phthisis, and, further, that all cases of miner's phthisis are associated with dust containing silica. Coal actually provides some degree of local immunity against tuberculosis. In this manner, when the strata between the coal seams in a mine contain a silicious quartz, the miner is prone to pulmonary fibroses, to bronchitis and to a rapid form of lobar pneumonia, but not to phthisis. Cotton strippers and others exposed for long periods to cotton dust develope a peculiar form of asthma, but not tuberculosis. There is another strange characteristic of miner's phthisis. The tuberculosis, in spite of its virulence and rapid course, is not readily transmitted to persons not exposed to the silicious dusts. The wives of sandstone workers, of tin miners, of cutlers, of flint knappers, of gannister workers and of granite cutters rarely acquire tuberculosis from their husbands, and it is stated that the proportion of widows is higher among certain miners than any other section of the whole population. Silicates possess no power of producing this form of tuberculosis. The pathology of silicosis is that of fibrosis, but there must be something added. Dr. Collis does not hazard an opinion as to the reason why silica alone of the dusts can give rise to fibrosis and tuberculosis. He points out that the mechanical characters may contribute to this, inasmuch as the particles are extremely minute and extremely angular and hard, while certain chemical properties may also play a part. Crystalline silica is acid on account of traces of free silicon, and the element may enter into direct chemical combination with the protoplasm of the cell. It is not impossible that the smell generated when silica is fractured is due to the volatilization of silicon, and that this gaseous product may further facilitate a chemical insult to the cell. In any case, the damage predisposing to fibrosis and secondary tubercular infection must be of a peculiar type, and the stimulus directed to the tissue cells probably extends to the tubercle bacilli, and causes their rapid development. While the bacilli induce an acute form of tubercular infection, the same stimulus simultaneously produces changes in them, impairing their infectivity.

[1] Milroy Lectures: Industrial Pneumonoconioses, with Special Reference to Dust-Phthisis. *Public Health*, August, September, October and November, 1915.

THE HOSPITAL SUNDAY FUND, MELBOURNE.

The Lord Mayor of Melbourne, as President of the Hospital Sunday Committee, has announced, through the public press, that the total subscriptions received in aid of the hospitals amounted to no less than £15,700, which constitutes a record. He congratulates the people of Melbourne on their humanity in having contributed so generously at a time when "the multiplicity of patriotic claims" might have provided a reasonable excuse for some shortage in the giving to other charities. We recognize in this liberal response a definite reply by the community to the suggestion that the hospitals should be taken over by the State.

Abstracts from Current Medical Literature.

SURGERY.

(10) Typhoid Perforation.

John H. Gibbon has undertaken a critical review of 139 cases of typhoid perforation and 16 cases diagnosed as this condition in the Pennsylvania Hospital from 1901 to 1915 (*Annals of Surgery*, October, 1915). It appears that out of a total number of 5,891 cases of enteric fever, 112 patients were subjected to operation for perforation and 27 others died of this complication without operation. The number of recoveries among the operated cases was 27, or 24.1%. The total number of deaths in the whole series was 481. The author points out that between 1909 and 1914, 15 operations were performed, and all the patients died, whereas in 1914-15 10 operations were performed, with 5 recoveries. The enteric fever general mortality during the five years was 7.8%, and in the past year was 8.8%. In endeavouring to discover why there were 15 consecutive deaths among those operated on for perforation in the one series, and a 50% mortality in the following year, he finds that during the former period the operation was undertaken on an average 20 hours after the perforation, while the average time elapsing during the latter period was 10 hours. He concludes that, provided that the physician and surgeon co-operate in all cases of abdominal pain in enteric fever, the mortality of perforation can be reduced materially. In the next place, he deals with a number of cases in which an operation was performed for a supposed perforation, and no perforation was found. In two fatal cases only were no lesions found to justify the operation. There were 16 patients, who were subjected to the operation on a faulty diagnosis. Of these, 10 recovered and 6 died. In 4 cases death resulted from another lesion. The author proceeds to analyse the conditions in those 27 cases in which death occurred from perforation without operation. One patient refused to submit to operation. In 7 others perforation was diagnosed, but the patients were dying at the time of admission. In three instances the perforation was overlooked, on account of delirium and profound toxæmia. After giving full details of all his cases, he deduces that the diagnosis of perforation must be made mainly from the symptoms, pain and rigidity. The pain comes on suddenly and rigidity becomes marked. As soon as a suspicion of perforation is present an exploration should be made. Rectal examination may reveal acute tenderness, which is significant. Difficult, painful or frequent micturition often occurs. Changes in pulse-rate and temperature are of no great diagnostic value. A leucocytosis is of importance, but it usually developes after from 8 to 12 hours. In conclusion, he deals with treatment.

(11) Carcinoma of the Small Intestine.

While cancer of the large intestines is a common condition, comparatively few malignant tumours have been met with in the ileum, and very few in the jejunum. Frank H. Lahey (*Annals of Surgery*, October, 1915) records two cases, one of cancer of jejunum, and the second of cancer of ileum. The first patient was aged 45. He had symptoms after eating for six months, and complained of loss of strength. A month before he vomited occasionally, and experienced relief from the discomfort after vomiting. There was marked constipation. On examination, the patient was cachetic in appearance, and the hæmoglobin value of his blood was 70%. There was a tender area in the region of the splenic flexure, and a hard moveable mass was felt deep down. A provisional diagnosis of carcinoma of the small intestine was made, and the patient was subjected to operation. After the abdomen was opened, a small tumour, apparently an annular carcinoma, was found in the jejunum, about 18 inches from the ligament of Treitz. Eighteen inches of bowel were resected, and an end-to-end anastomosis carried out. The pathological report revealed the tumour to be an adeno-carcinoma. The patient made a good recovery, and was well 14 months after the operation. In the second case there was a history of diarrhœa for seven months, and constipation for one. The patient complained of attacks of colic, abdominal pain and loss of strength. A hard mass, the size of an egg, was felt above the umbilicus. It was not tender on pressure. An operation was performed and a small discrete carcinoma of the small intestine, about six feet from the ileo-caecal valve was found. There were practically no large glands in the mesentery. One-and-a-half feet of bowel, together with a wedge-shaped piece of mesentery, were excised, and an end-to-end anastomosis made. The patient recovered, but died five months later of recurrence.

(12) Gall-Stones Associated with Transposition of Viscera.

The complete transposition of viscera is a condition of considerable rarity, and when it exists, difficulty may be experienced in recognizing certain pathological conditions of the viscera. H. W. Horn records a case of a woman, aged 51 years of age, whose liver dulness was found on the left side, whose cardiac dulness was found on the right side, and whose other organs were also transposed (*Annals of Surgery*, October, 1915). The patient complained of pain in the left hypochrondrium. This pain had been worse during the past 12 months, but had been present for 30 years. It radiated toward the left shoulder blade, and downward over the left half of the abdomen. There was marked tenderness. The diagnosis of gall-stones was made, and an operation performed. The gall bladder was found on the left side. Its walls were thickened, and contained about 70 c.cm. of greenish black bile, and four mulberry stones.

(13) Dilatation of the Duodenum.

W. Howard Barber (*Annals of Surgery*, October, 1915) has undertaken an experimental study of the mechanism of dilatation of the duodenum, and has incidentally examined the question whether there is any causal relationship between incomplete obstruction of the caudal end of the ileum and dilatation of the duodenum. It is known that incomplete obstruction of the lower end of the colon is associated with dilatation and increased dilatability of the cephalic end of the colon. A similar association has been observed in connexion with the ureter. Various explanations have been offered for the occurrence of duodenal dilatation. It has been suggested that the circular fibres, situated 2.5 cm. beyond the entrance of the common bile duct, act as a sphincter, and may work in concert with the ileo-caecal valve and the pylorus. Lane has accounted for the phenomenon on a mechanical basis. In order to determine the factors at play, the ileum, 3 cm. from the ileo-colic junction, was loosely constricted with gauze. Means were adopted for determining any definite relaxation or increased dilatability of both the ileum and the duodenum. As a result of these experiments, it was found that incomplete obstruction of the extreme caudal end of the ileum gives rise to dilatation and increased dilatability of the cephalic end of the duodenum. Complete obstruction of the ileum, however, does not give rise to any apparent change in the duodenum. Incomplete obstruction of the cephalic end of the colon, or purulent typhilitis, does not apparently decrease the dilatability of the cephalic end of the duodenum. While the author is cautious in drawing conclusions, he finds sufficient evidence to state that an incomplete obstruction permits the free intercommunication of the duodenal and caecal centres, through Auerbach's plexus, whereas a complete obstruction interferes with this relationship. Abnormal caecal stimuli may have the same cumulative effect upon a duodenal centre as the abolition of these stimuli. In incomplete iliac obstruction the duodenum labours to the point of fatigue and dilatation under an excessive physiological load. In the case of complete iliac obstruction, there is a conservation of the duodenal contractile power, and a preservation of the tone of the duodenum.

(14) Myeloid Tumours of Tendon Sheaths.

M. J. Stewart and E. R. Flint (*Brit. Journ. of Surgery*, July, 1915) records two cases of myeloid tumour involving tendon sheaths. Up to the present, 73 of these cases have been recorded. According to Heurteux they are either composed largely of embryonic cells and characterized by rapid growth and a tendency to invade the surrounding structures (true sarcoma), or are tu-

mours in which the myeloplaxes are associated with an adult type of stroma. In the latter instance the tumour grows slowly and remains localized. In the first case a small tumour was found on the ulnar aspect of the right thumb. It was removed under cocaine and adrenalin anæsthesia. The wound healed by first intention, and all movements of the thumb were regained. In the second case the tumour was situated on the extensor aspect of the left wrist, and a smaller growth appeared in the flexor aspect. Both were removed, and the hand regained its functions. There was no recurrence. The histological examination in the first case disclosed spheroidal and polygonal cells in alveolar arrangement. In addition, there were multinucleated giant cells of the myeloid type in considerable numbers. The stroma was composed of dense fibrous tissue. The authors consider that the structure corresponded to an endothelioma. The histological characters of the second tumour bore a close resemblance to that of the first growth, but there were, in addition to the other constituents, a number of foamy cells, sometimes spoken of as lipoid or xanthoma cells.

GYNÆCOLOGY AND OBSTETRICS.

(15) The Placental Stage of Labour.

Polak (*Surgery, Gynaecol. and Obstet.*, November, 1915) has made a study of 2000 deliveries, and comes to the conclusion that no attempt should be made at manual expression of the placenta until clinical evidence of separation, *i.e.*, descent of the cord, rise of the fundus in the median line, with flattening of the uterus from before backwards, and a gush of blood from the vagina, is present. The patient should be asked to bear down, and the placenta usually escapes from the vulva without any manipulations at all. If the placenta does not escape, Credé's manœuvre may be employed. Clinical signs of separation may become apparent in from 15 minutes and 2 hours. He confirms Ahlfeld's contention that an attached placenta or a completely detached placenta prevents hæmorrhage. The physiological separation of the placenta is hastened if the uterus is not handled after manipulation, and active manipulations within the uterus favours retention of the placenta and membranes by interfering with the physiological processes. He holds the opinion that adherent placenta is extremely rare. Only one genuine case occurred in his series of 2000. In the majority of cases the retention is due to the detached placenta remaining in the dilated lower segment of the uterus and cervix. He makes the assertion that 10% of patients with adherent placentæ, which have been removed manually, die from sepsis. Manual extraction is therefore only admissible in partial separation of the placenta with severe hæmorrhage. He maintains that the placenta may be retained for hours or days without danger to the patient, provided that it is attached or completely detached, which insures that the bleeding will be negligible. His experience has taught him to allow nature to take its course without interference, provided that hæmorrhage or other complications do not endanger the patient's life.

(16) Deficient Lactation.

Haeney holds the opinion that the failure of the breasts to engorge on the second to the fourth day is an extremely rare occurrence (*Surg. Gynaecol. and Obstet.*, November, 1915). On the other hand, unless the child suckles at the breast, or the milk is withdrawn artificially, the breasts gradually dry up, and milk is no longer secreted. He therefore concludes that deficient lactation is due to the inability of the child to empty the breast. When this occurs the residue should be withdrawn by means of a breast pump, or by manual milking. The child often falls asleep while suckling during the first few days of life. When this takes place, means should be adopted to keep it awake during the process by the application of cold to the feet or other irritation. Giving frequent drinks of water to the infant not only keeps it awake, but also maintains its weight. Among the causes of insufficient emptying of the breasts the following may be enumerated as the most important:—An indolent infant, occlusion of the ducts, and failure of the gland to secrete freely. In the last-named condition, the best galactagogue is stimulation of the gland by withdrawing the contained milk. This fact should be as well appreciated by the obstetrician as it is by the dairyman. Emotional states may influence the secretion of milk, such as fright, an irritating nurse, husband or mother-in-law. Painful impressions, sleeplessness, or anything that interferes with the psychic rest of the patient may also decrease the secretion. The physical condition of the patient, severe hæmorrhage, profuse lochia, or drugs such as ergot, may also have an influence in lessening the activity of the breasts. An abundance of nourishing food is helpful, but cramming is harmful. No particular food or drug has any specific action as a galactogogue; the constituents of milk cannot be influenced by diet or medicines, as is commonly believed. When supplementary feeding of the infant becomes necessary, care must be taken not to give too much, lest the infant refuses to take the breast properly. He advocates in addition to pumping the breasts out after the baby has fed, the application of Bier's hyperæmia four times a day. The suction should be sufficient to cause slight engorgement, which should be maintained for 15 minutes. These measures usually suffice in producing an ample secretion of milk in a week or ten days.

(17) Nitrous Oxide in Labour.

Heaney (*Surg., Gynaec. and Obstet.*, September, 1915), after reviewing the literature on the use of nitrous oxide to secure painless labour from Klikowitch, of Petrograd, in 1880, to the employment of nitrous oxide and oxygen by Lynch, in 1913, proceeds to describe his own use of the drug, which he has found eminently satisfactory. With a proper machine and nasal inhaler, he was able to administer nitrous oxide to the extent that the patient did not experience pain during labour, and yet maintained consciousness. If oxygen were given at the same time, this stage of analgesia was more easily maintained and the after headaches were less frequent. He states that the amount of gas needed to produce this stage of analgesia depends on two factors; the efficiency of the machine used and the susceptibility of the patient. The less nitrous oxide required to produce analgesia the more oxygen is necessary. Usually, the mixture is of such a strength that three or four quick inhalations at the beginning of a pain are sufficient to produce analgesia, while the patient retains her normal colour and remains entirely conscious. When once analgesic more oxygen may be given until at the end of a long pain either pure oxygen is given or the nose piece is removed. If the mixture is too rich the analgesia is imperfect, and the patient passes into a deeper stage, and may complain of pain. She then begins to become cyanotic, consciousness becomes clouded and if the inhalation is pushed further the patient enters the final stage of surgical anæsthesia. With the inexperienced the tendency is always to give too much. Lynch advises that patient should be directed to keep her eyes open and fixed on a light. If the light begins to appear clouded or the eyelids begin to droop or the lips become cyanosed, the patient is directed to take deep breaths through the mouth. The desired degree of analgesia soon returns. The administration may be begun at any time when the pains begin to be severe. The hand placed upon the abdomen feels the contraction of the uterus before the patient perceives the pain. At this time the nasal inhaler is placed over the patient's nose, and she is directed to take the necessary number of inhalations previously determined. In the second stage she holds her breath and bears down. When this breath is exhausted, if well within the analgesic zone, she breathes again through the nose. Some oxygen is then added to the mixture. By questioning the patient between pains, the mixture necessary to obtain the ideal result is quickly determined. To insure absolute painlessness, gas may be given to the surgical degree during the last few pains. In a few cases he performed manual dilatation and other procedures; the patient was entirely conscious, but experienced no pain. The frequency and duration of the pains are in no way interfered with, and the fœtal heart tones are not disturbed. Moreover, the baby cries immediately on birth. There is no relaxation of the uterus. He concludes by saying the staff of the Presbyterian Hospital hold the opinion that they have in this method an efficient and safe means of controlling the suffering methods.

Medical Societies.

(Affiliated with the British Medical Association.)

NORTH-EASTERN MEDICAL ASSOCIATION, N.S.W.

A meeting of the North-Eastern Medical Association was held at Casino, New South Wales, on December 10, 1915, Dr. Page, the President, in the chair.

A letter from Dr. A. J. Cahill was read, in which he asked to be relieved of his office as a member of the Committee.

Dr. Cahill is proceeding to the front.

A letter was read from Dr. Monti, resigning his membership of the Association.

A letter from the Principal Medical Officer of the 1st Military District was read. The attention of the Association was directed to the urgent need for medical officers in the military camps in Brisbane.

A letter from the Secretary of the Bangalow Friendly Societies' Association was read, asking that the Bangalow doctors be allowed to visit the Federal Lodge once a week. Other letters from medical practitioners in connexion with Lodge work were also read.

It was resolved that the resignation of Dr. Cahill from the Committee be accepted with regret, and that he be granted extended leave of absence from the Association during the currency of the war. It was agreed that Dr. Monti be asked to reconsider his resignation.

It was determined that a letter be addressed to practitioners, acquainting them of the need for medical officers in the camps in Brisbane.

Moved by Dr. Opie, seconded by Dr. Evans, and carried that a letter be sent to the Secretary of the Bangalow Friendly Societies' Association, calling his attention to a rule forbidding the action requested.

A number of letters from Dr. R. H. Todd, the Honorary Secretary of the New South Wales Branch of the British Medical Association were considered. These letters dealt with a scheme for the protection of the practices of members absent on naval or military service, the War Emergency Organization, the uniform rules for local Associations, the annual meeting of delegates, the Phœnix Mutual Provident Society, Limited, and other matters.

It was determined that further information should be obtained in regard to the Phœnix Mutual Provident Society.

The minutes of the annual meeting of delegates of the Affiliated Local Associations with the Council of the New South Wales Branch were read. Dr. Page explained the resolutions.

Dr. Page read a leading article published in the November issue of the *Australasian Nurses' Journal*, dealing with registration of private hospitals in the country. The members took great exception to this article. After some discussion it was moved by Dr. Robertson, seconded by Dr. Opie, and carried:—

> That the attention of the Council be drawn to this unwarranted slander on the country members of the medical profession, and that it be asked to take some action in the matter.

It was resolved, on the motion of Dr. Page, with the support of Dr. Evans:—

> That the Secretary be instructed to secure a supply of certificate forms, setting out the income limit for use by candidates for admission to Friendly Societies, and that such be forwarded to all Lodge Secretaries in the district, with a request that they be used in all such cases.

It was determined that the consideration of the draft rules for local Associations be deferred until the next meeting. It was moved by Dr. Page, seconded by Dr. Robertson, and resolved:—

> That the Secretary be instructed to write to such members as have not replied to the scheme for assisting isolated practitioners, asking them to reply within one week; failure to reply to be deemed a negative answer. And that a list of such practitioners as are willing to support the scheme be forwarded to each member.

Dr. Opie moved, and Dr. Tomlins seconded:—

> That this meeting of the North Eastern Medical Association would deplore and view with alarm any alteration by the Branch Council of the Common Form of Agreement.

This motion was carried.

The next motion was proposed by Dr. Graham and seconded by Dr. Evans, and was carried. It was to the following effect:—

> That members of this Association disapprove of any reciprocity between members and practitioners ineligible for membership.

On the motion of Dr. Evans it was resolved:—

> That some step should be taken to organize a scheme to meet a national emergency in view of the present crisis, and that a sub-committee consisting of Drs. Parker, Coen, Opie, Bignell, and the Secretary be appointed to formulate a scheme to arrange to carry on the practices of men desirous of leaving for the war, and so set them free for military service.

For the guidance of this sub-committee, the following suggestions were made:—

> That a local census be taken, and that members be asked to furnish replies to the following questions:—
>
> (1) Are you prepared to undertake medical work abroad?
>
> (2) Are you prepared to undertake medical work in the Commonwealth?
>
> (3) Are you willing to undertake the work of another practitioner (*a*) in your own town, or (*b*) in another town in this district, at the request and under the auspices of the Association, in order to enable him to go the war?
>
> (4) Are you willing to undertake camp duty at Brisbane (*a*) for a short period, say, three week, or (*b*) for a longer period?

THE CITY MEDICAL ASSOCIATION (N.S.W.).

The annual meeting of the City Medical Association was held on December 15, 1915, at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, Dr. A. J. Spiller Brandon (the President) in the chair.

Dr. A. Maitland Gledden submitted his report as Delegate of the Local Medical Association and as Representative on the Council of the New South Wales Branch. A vote of thanks for his valuable services was carried by acclamation.

The Honorary Treasurer presented a report, showing a credit balance of £7 6s. 6d.

The following officers were elected for the ensuing session:—

President: Dr. John Harris.
Vice-President: Dr. J. C. Windeyer.
Honorary Secretary: Dr. C. E. Corlette.
Honorary Treasurer: Dr. E. Selwyn Harrison.
Members of the Committee: Drs. A. Maitland Gledden, A. J. Spiller Brandon and George Bell.
Delegate: Dr. A. Maitland Gledden.
Representative to Council: Dr. A. Maitland Gledden.
Representative to the Sydney and Suburban Provident Medical Association: Dr. A. J. Gibson.
Honorary Auditor: Dr. Donald Luker.

THE HOME OF THE QUEENSLAND BRANCH.

The balance sheet and profit and loss account of the Queensland Medical Land Investment Company, Limited, for the year ending on November 24, 1915, are documents of interest to members of the British Medical Association in Australia, since they disclose the progress by means of which an important Branch is gradually acquiring its own home. In four of the States the advisability of having as property of the Branch a valuable building has been recognized, and steps have been taken to acquire for the Branch this property. In Queensland, a company was formed for the purpose of giving the Branch a room to meet in. The nominal capital of this company was £7,000, but only 5,650 shares were issued, and up to the present, only 10s. per share has been paid up. In addition, a mortgage of £3,100 was effected on the building. It thus appears that when the company can repay the £2,825 to the shareholders, the building will pass over to the Branch. The first task in the way of repayment appears to be to wipe off the mort-

gage. On a previous occasion the mortgage was reduced by £200, and this year a further sum of the same amount is being paid back.

The room set aside for the meetings of the Branch are let out on occasions to the local branch of the Australasian Trained Nurses' Association, to a class of ladies, who have listened to lectures on first-aid by Dr. W. Wilton Love, and to the Historical Society. We offer the director, Dr. W. N. Robertson, and the members our sincere congratulations on the marked success which is attending this undertaking.

QUEENSLAND MEDICAL LAND INVESTMENT COMPANY, LIMITED.

Profit and Loss Account for Twelve Months ending 24th November, 1915.

	£ s. d.	£ s. d.
Nov. 25, 1914—		Nov. 24, 1915—
To Balance	49 6 5	By Rents	551 10 0
Nov. 24, 1915—		
To Interest on Mortgage	£155 0 0	
„ Rates	52 0 0	
„ Insurance	9 16 6	
„ Secretary's Salary	20 0 0	
„ Bank Charges	1 8 4	
„ Postage and Stationery	0 15 0	
„ Audit	4 4 0	
„ General Expenses	1 14 6	
„ Rent of Electric Fans	3 15 0	
„ Watchman and Cleaning	16 9 0	
	265 12 10	
„ Depreciation on Adelaide Street Property	£79 7 0	
„ Depreciation on Furniture and Fittings	8 0 0	
„ Proportion of Preliminary Expenses Written Off	7 0 0	
	94 7 0	
„ Balance	142 3 9	
	£551 10 0	£551 10 0

Balance Sheet as at 24th November, 1915.

LIABILITIES.	£ s. d.	£ s. d.	ASSETS.	£ s. d.
Nominal Capital—7,000 Shares of £1 each	7,000 0 0		Adelaide Street Property	5,594 12 6
Less Unissued 1,350 Shares of £1 each	1,350 0 0		Furniture and Fittings	72 0 0
	5,650 0 0		Sundry Debtors	31 0 0
Less Uncalled 10s. per Share on 5,650 Shares	2,825 0 0		Preliminary Expenses	14 0 0
		2,825 0 0	Unexpired Proportion of Rates and Insurance	12 0 4
Loan on Mortgage		3,100 0 0	Credit Balance, Bank of North Queensland, Brisbane	366 1 5
Sundry Creditors		25 16 8	Cash in Hand	3 6 2
Profit and Loss Account		142 3 9		
		£6,093 0 5		£6,093 0 5

W. N. ROBERTSON, Director.
ELVA THOMSON, Secretary.

I have examined the Books and Vouchers of the Queensland Medical Land Investment Company, Limited, and hereby certify that the above Balance Sheet exhibits a true and correct statement of its affairs as at November, 1915.

Brisbane, 29th November, 1915.

ROY G. GROOM, Auditor, F.C.P.A.

Public Health.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending December 31, 1915:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Totals. Cs.	Dths.
Diphtheria	45	6	18	1	63	7
Scarlatina	11	0	1	0	12	0
Enteric Fever	2	0	9	0	11	0
Pulmonary Tuberculosis	8	3	3	1	11	4

The following is the return of cases of epidemic cerebro-spinal meningitis reported to the Board during the week ending December 31, 1915:—

	Metropolitan Area. Cases.	Rural Districts. Cases.	Totals. Cases.
Military	—	—	2
Civil	6	2	8

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending December 25, 1915:—

Disease.	No. of Cases.
Diphtheria	24
Scarlet Fever	4
Enteric Fever	50
Pulmonary Tuberculosis	10
Varicella	3
Cerebro-Spinal Meningitis	2
Erysipelas	1
Total	94

SMALL-POX IN NEW SOUTH WALES.

The following cases of small-pox have been reported to the Department of Public Health, New South Wales, during the fortnight ending January 7, 1916:—

	Cases.
Sydney (infected at Newcastle)	3
Country—	
Newcastle	9
Taree	3
Total	15

TASMANIA.

The Acting Chief Health Officer, Dr. Arthur H. Clarke, has issued the annual report of the Department of Public Health of Tasmania for the year 1914-15. During the greater part of the year the administration was in the hands of Dr. McClintock, whose resignation was accepted on September 9, 1915. In the opening chapter it is stated that the increase in the Department's activity during the year has been phenomenal, and that, owing to the Chief Health Officer having been appointed Royal Commissioner on two occasions, it has not been possible for him to visit several of the local districts, which, under ordinary circumstances, should have received attention.

Vital Statistics.

The estimated population of Tasmania on the last day of December, 1914, was 201,416. The mean population is given at 198,372, which represents an increase of 2,386 on the preceding year. In 1914, the birth-rate in the State was 30.33, which was higher than the birth-rate recorded in other States. The rate was only slightly lower in Queensland, although in 1913 it was higher. There were 172 deaths of infants under one year of age, which is equivalent to a death-rate of 8.77 per 10,000 of population. A satisfactory condition is recorded in regard to the death-rate in the State. In 1914, Tasmania held the second place among the Australian States. The death-rate was 9.67 per 1,000 of population. In Western Australia it was 9.41, in Queensland it was 9.97, in New South Wales it was 10.11, in South Australia it was 10.71, in Victoria it was 11.59, and in Northern Territory it was 21.59.

A short analysis of the causes of death is appended. It appears that diseases of the digestive organs were responsible for death in 12.05 per 10,000 persons living. These diseases, however, include a large class of infective processes, *viz.*, those of *cholera nostras* and other forms of enteritis. In 1913, the rate was considerably lower (7.95). Diseases of the circulatory system caused death in 11.04 per 10,000 in 1914, and in 12.24 in 1913. It is not stated whether deaths from cerebral hæmorrhage are included in this group, and inasmuch as apoplexy is usually classified under diseases of the nervous system, it is probable that they have not been so included. It therefore appears that in Tasmania, as elsewhere, diseases affecting the cardio-vascular system are responsible for more deaths than diseases affecting any other system. The next group in point of importance is that of the diseases of the respiratory organs. Here again infective processes are certainly included, inasmuch as the pneumonias and the bronchitides are merely localized infective processes. The mortality was 10.89 per 10,000. Fourth on the list comes diseases of the nervous system, with 9.48. It is probable that this figure would diminish very considerably were the cerebral hæmorrhages excluded. The giving way of a cerebral vessel as a result of some degenerative process cannot be regarded as a process of nervous origin. The fifth group is that of diseases of early infancy, which were responsible for 9.27 deaths per 10,000 persons living. The frequency of deaths from cancer comes next, and is tabulated at 7.26, while tuberculosis follows with 6.05. The only other group of deaths of marked frequency is that headed accident or negligence. Enteric fever caused 12 deaths, or 0.61 per 10,000; pertussis 10 deaths, or 0.5 per 10,000; diphtheria 33 deaths, or 0.86 per 10,000, and syphilis 3, or 0.15 per 10,000.

In pleading for sanatorium treatment as a prophylactic and curative measure for all cases of tuberculosis, the Chief Health Officer gives the number of deaths from pulmonary and other forms of tuberculosis and the death-rates for the previous ten years. In 1905 the phthisis death-rate was 75 per 100,000 of population, in 1906 it was 66, in 1907 it was 40, in 1908 it rose again to 59, to decrease in 1909 to 49, in 1910, 1911, and 1912 it was 38, 23 and 20. This apparent improvement was not maintained, in that the death-rate rose again in 1913 to 55, and in 1914 was 47. The death-rate of all forms of tuberculosis was 99 per 100,000 in 1905, and has diminished steadily until 1914, when it was 60. A special paragraph is devoted to enteric fever. Attention is called to the fact that the number of deaths from this disease has decreased during the past four years. In the year under review, 150 cases were notified, of which 12 proved fatal. In regard to diphtheria, the incidence has increased markedly since 1905. In that year there were 88 cases, with 10 deaths. The increase was comparatively gradual up to 1910, while in 1912 no less than 1,156 cases, with 35 deaths, were recorded. In the following year there were 937 cases and 38 deaths, and in the year under review 931 cases, with 25 deaths. The death-rate per 10,000 of population shows that in 1905 0.6, in 1912 1.82, in 1913 1.93, and in 1914 1.26 persons died. On the other hand, the case mortality was 11.36% in 1905, 3.1% in 1912, 4.05% in 1913, and 2.68% in 1914. It would thus appear that the incidence of the disease has increased out of proportion with the increase of population, while the morbidity has decreased considerably. The figures suggest that if antitoxin were used at an earlier date and in sufficient dose, the number of deaths could be reduced to a not inconsiderable extent. Scarlet fever, too, has become more frequent during the last ten years. With this increase of incidence the number of fatalities has diminished. During the past three years, there were 159, 225, and 223 cases respectively, while the number of deaths in the three years was 2, 0, and 1.

Sanitary Inspectors.

A course of lectures for students preparing for examination of the Royal Sanitary Institute was held, and 17 of these students submitted themselves for examination. Certificates of competency as inspectors of meat and other foodstuffs were accorded to two candidates, while six health inspectors' certificates were granted. The arrangements connected with slaughter-houses in Devonport do not appear to have been very satisfactory. In New Norfolk it was found necessary to draw attention to several breaches of the by-laws controlling the condition of slaughter-houses.

The Chief Health Officer calls attention to the necessity of a defined area being proclaimed an "offensive trade area" for Hobart.

Food and Drugs Act.

In the chapter dealing with the Food and Drugs Act, 1910, attention is called to the new standards which have been adopted in Victoria and Western Australia. In the regulations in the latter State, the chief variations affect infants' foods and whisky. The Chief Health Officer states that one of the difficulties in carrying the provisions of the Food and Drugs Act is found in the absence of a Food Standards Advisory Committee. During the year, 234 samples of food and drugs were examined in the Government Laboratory. Of 92 samples of spirits, five were found to have been adulterated with water below the legal limit of 25% under proof. Milk samples were taken on 114 occasions, and in six instances the analysis showed dilution. The greatest deficiencies were 12.5% of solids not fat, 11.6% of milk fat, and 8% of total solids. These deficiencies are calculated on the standard minimum prescribed by regulation. Of eleven samples of butter, two were found to be artificially coloured, and one to contain an excess of salt. A sample of honey was found to be unlike that of genuine honey, although the chemical analysis failed to reveal any actual differences.

Midwives.

The Midwives Act, 1911, came into operation on January 1, 1912. Under its regulations, the examination of candidates is provided for. Up to June 30, 1915, only 284 out of 575 midwives on the register took out annual certificates. During the year under review, 28 additional names were placed on the register. Police court proceedings were in-

stituted in certain cases, in which women were found to be practising in contravention of the Act.

Factories.

A chapter is devoted to the working the Factories Act, 1910. The sum of £420 18s. was received in payment of fees for registration. One-half of these fees is paid to the local authority, and the other half to consolidated revenue. On June 30, 1915, 7,787 persons were employed in factories. Of these, 365 boys and 148 girls were between the ages of 14 and 16, 1,106 males and 671 females between 16 and 21, while 4,690 males and 807 females were over 21 years of age. The number employed in 1912 was 7,841, and in the two following years was greater than the number employed in 1915. The only prosecutions undertaken under the Factories Act were for failure to register the premises. A number of tables dealing with the various aspects of the trades included within the scope of the Act are appended.

The next chapter deals with the Wages Boards Act, 1910. Much of its contents is of interest, although it has no special bearing on medicine or hygiene. The same applied in respect to the chapter of the Shops Closing Act, 1911 and 1913.

Vital Statistics.

SYDNEY AND NEWCASTLE.

The November returns of the Government Statistician, dealing with the births and deaths in Sydney, have been published in the New South Wales Government *Gazette* on December 8, 1915. During the month there were 1653 births, 860 of which were of males and 793 of females. The birth-rate, calculated as an annual rate, was 25.36. This compares unfavourably with the average for November during the past five years, which works out at 30. There were 101 illegitimate births as compared with 142, which was the average for November in quinquennial period. The illegitimate birth-rate was 1.61 as compared with 2.27. This rate is 29% below the average for the previous five years. Of the 1653 births 292 took place in hospitals and other public institutions.

The infantile mortality was considerably higher in November, 1915, than in the preceding five months of November. There were 239 deaths of infants under one year of age, which gives an infantile mortality of 145 per 1,000 births, whereas the average for the previous five years was 85. The deaths of persons between 1 and 4 years of age numbered 96, and of 65 years and over 179.

The total number of deaths during the month was 866. This corresponds to an annual death-rate of 13.81. The average for November of the previous five years was 10.81. The deaths occurring in hospitals and other public institutions represented 43% of the total.

The Statistician appends the usual tables dealing with the monthly records of births, deaths and meteorology, infantile mortality and principal causes of death.

The most prolific cause of death was diarrhœa and enteritis; this was responsible for 199 deaths, 168 of which affected children under 2 years of age. Tuberculosis comes next of the infective processes, with 42 deaths. In 33 cases the disease was pulmonary. There were 37 deaths from pneumonia, 15 from broncho-pneumonia, 13 from diphtheria, 9 from chronic bronchitis, 8 from pertussis, 8 from enteric fever, 7 from scarlatina, 6 from morbilli, 6 from acute bronchitis, 6 from acute rheumatism, 5 from cerebro-spinal meningitis, 3 from acute endocarditis, 2 each from dysentery, erysipelas, septicæmia, and simple meningitis, and 1 from influenza. In addition, 5 deaths are entered under the rubric syphilis. Diseases of the cardio-vascular system caused 105 deaths. Of these 64 were due to organic diseases of the heart, 19 to cerebral hæmorrhage, and 10 to atheroma. There were 56 deaths from cancer, 20 of which are entered as cancer of the stomach and liver, 13 as of the peritoneum and intestines, 9 of the female genital organs, 4 of the mouth, 1 of the breast, and 1 of the skin. Of the diseases of the urinary system, Bright's disease caused 40 deaths, acute nephritis 7, and other diseases of the kidneys and adnexa 5. Of the 8 deaths recorded as being due to accidents or disease in the puerperal state, 3 are ascribed to puerperal albuminuria and convulsions, 3 to accidents of pregnancy, and one each to puerperal hæmorrhage and puerperal septicæmia.

The returns for the Newcastle district are also given.

The number of births during the month was 153, which is equivalent to an annual birth-rate of 31.32 per 1,000 of population. There were 7 illegitimate births, which is equal to an illegitimate birth-rate of 1.44.

There were 95 deaths, which is equivalent to an annual death-rate of 19.44. Of the 95 deaths 27 affected infants under 1 year of age; the infantile mortality was consequently 176 per 1,000 births. The highest infantile mortality in the preceding 13 months was 155 in November, 1914, and the lowest was 47 in February, 1915.

There were 29 deaths due to diarrhœa and enteritis. In November, 1912, this number was exceeded by 4, while in November, 1914, the number was only 8. There were 3 deaths from tuberculosis, 4 from pneumonia, 1 from broncho-pneumonia, 3 from chronic, and 1 from acute bronchitis, 1 from measles, 1 from diphtheria, and 1 from tetanus. Cancer killed 5 persons, and diseases of the cardio-vascular system killed 8.

Proceedings of the Australasian Medical Boards.

NEW SOUTH WALES.

A Disciplinary Case.

(*Continued from page* 13.)

On December 3, 1915, Mr. Robison continued his cross-examination. Mr. King, a nephew of Probst, had introduced his uncle to him. He had never seen King before. He witnessed the cross on the cheque, because he understood that the bank required this. One the cheques might have been signed prior to the operation. He was also asked to witness the signature to a will. Dr. Caro had said that the witness Patrick Stokes must be present before he would read the will. Probst heard the will read, and made no demur in regard to the property, but he did in regard to the cash in the bank. Witness therefore refused to sign it. He did not know that Probst had no more money in the bank. He understood that he had £2,000.

Mr. Robison questioned witness in regard to his conception of what touting was. He admitted that soliciting custom was touting, but denied that he did solicit custom. He was then asked why he gave Cherry 100 visiting cards. In reply, he said he did this at Cherry's request, just as he had given cards to patients at their request before. He knew when he gave Cherry the cards that the latter had not 100 patients to send. He gave them because he knew he would have 100 patients. He admitted it was for the purpose of giving to people who would become his patients. He knew that Thomas and Cherry were obtaining patients for him at the train and at the hotels.

Daly had come to him about three years ago. He did not know Daly before he arrived at the place. He had attended him once or twice for drunkenness. Daly had said, "I have brought you a patient," and had asked for a present. Dr. Caro admitted that he could tell of other medical men who did the same thing, but he declined. Mr. Robison asked him why he did not tell their names if there was nothing wrong, and witness replied, "Since I have come here I fancy there is something wrong." He also gave similar evidence in regard to the man Keys. Dr. Caro was also questioned at some length in regard to his claim to be a specialist in diseases of digestion, of the eye, ear, nose and throat.

Mr. Robison then examined Dr. Caro in regard to the Jamieson case. Jamieson was a periodical alcoholic. On January 2, 1915, Jamieson went to his hospital. Witness considered that his condition was serious, from heart failure, due to becoming frightened and ceasing alcohol too quickly. He saw him about three times each day in his hospital. There was a qualified nurse in the hospital, but she was not certificated under the Act. He gave the nurse her certificate. She was his wife's sister. The patient was getting steadily worse during the first two days. In the afternoon of the third day his condition was serious. Witness, his wife's sister, and another man were in the patient's room in the afternoon. Witness prepared a will,

He had prepared many another will. He was not in the habit of preparing wills for patients, unless the hour was such that he thought that there would be difficulty in obtaining a legal man, or the man did not wish it, or the amount was so small that it did not seem worth while. In other wills prepared by him, he was not sole legatee. He admitted that he was in this case "for charitable purposes." Witness admitted that the will formed the subject of a probate suit, in which he was the plaintiff. The Judge had refused to grant him probate, on the ground that the only evidence as to the testator's mental capacity about the time of the execution of the document was that of Dr. Caro, and was insufficient to establish affirmatively that he knew what he was doing when he made the will. Witness admitted that, with one exception, all the persons who could have given evidence as to Jamieson's mental capacity were members of his own staff. Witness had asked Jamieson if he wished to make a will, as he believed that he would die within twelve hours. The reason he did not suggest sending for a lawyer was that he understood that they "closed at 5 p.m.," and that he did not think that the man had sufficient money to make it worth while. After the will was executed, he gave two injections of morphine, each of a quarter of a grain. The man went to sleep about two hours later, awakened, went to sleep again, and died at 12.45. The entry in the book was made by Miss Harrison, his sister-in-law. He altered the entry from 11.53 to 12.45, because he happened to look at his watch, and noticed the time. He admitted that nurses and matrons not infrequently made mistakes; and doctors, too. He had given a wrong cause of death of this man; he had said that he died of uræmic poisoning. Witness admitted that the Judge had pointed out that the certificate was inaccurate, and that the Judge had said that he was not satisfied as to his genuineness. He was satisfied that he had acted as a reputable man should have acted in regard to the will in the Jamieson case.

In reply to Mr. Breckenridge, Dr. Caro repeated the story told at the probate case of an event which had determined him to have nothing to do with the British Medical Association. He had come to Sydney under contract to take charge of a hospital at Summer Hill. When he took it over, it was not a scientific institution. He turned it into a thoroughly qualified, scientific hospital. About 13 years before, a patient, who was dying, after an abdominal operation for peritonitis, expressed a wish to see a doctor. He wished to call in a medical man who was an officer of the Branch of the B.M.A. When asked to come to consult over the telephone, the practitioner replied, "I am damned if I will come." Dr. Caro said, "Here is a dying woman; for the sake of humanity I plead with you to come and see her." The doctor replied, "I am damned if I will." From that time he had no consultation with a member of the British Medical Association, "because they were refused." His hospital was a thoroughly scientific hospital, run on ethical lines. The doctor's name was Dr. Ralph Worrall. The woman died about five hours later. On one occasion a member of the British Medical Association did come to his assistance, in a case of severe hæmorrhage. He believed that the doctor notified the British Medical Association of the fact. He had been blacklisted by the British Medical Association; he had never shown any animus to them, except by taking a lodge they disapproved of. Being a man they objected to, he thought that this was fair. After he had held the lodge for a year he came to the conclusion that the B.M.A. men were right in their controversy, and he therefore gave up the appointment.

Dr. Caro maintained that the first intimation that he had behaved unethically was given him when Mr. Kench handed him the summons. He was prepared to conform to a standard that was laid down by the Medical Board. He did not know that he was doing anything amiss. He had always refrained from any guarantee to a patient. He claimed that his fees were fair and just for the work undertaken.

Witness was questioned in regard to medical men having large advertising signs on their houses. He assumed that this would be regarded as a form of attracting patients. That was very much in the same way as he had done himself. In reply to Mr. Robison, witness stated that he did not put himself in the category and class as the medical men referred to. Everybody knew that it was not professional to put a great sign across the front of a house. He contended that a man who had been trained in the United States of America should be excused for having placed a basket on the desk of his waiting room containing his professional cards, to be taken away by patients for their friends. He did not know that the class of business carried on by the men with large advertising boards was venereal disease. Mr. Robison asked him: "Do you tell this Board seriously that you, as a medical man, after having read their advertisements, did not know that they are what are commonly called 'quack doctors'?" Witness replied: "I will say no sir. I have no idea . I would like to modify that. A man cannot remember everything. . . . I absolutely do not know what they have on their boards, but I do know that they have boards up. I suppose that it is three years ago since I even saw their boards."

Herbert Reginald Palzer, a clerk in Messrs. Johnson & Herford's office, gave evidence to the effect that he had that morning gone down Elizabeth Street, and copied the wording of the various advertisements on medical men's places. Mr. Robison attempted to obtain an explanation of the reason for making these copies.

Dr. Ralph Worrall, a legally qualified medical practitioner, stated that he could not remember a patient named Mrs. or Miss Sharpe, whom he was supposed to have treated 19 or 20 years before. Mr. Robison asked whether he had been rung up by Dr. Caro on some matter 19 years ago, and had been asked to meet Dr. Caro in consultation, and whether he had said that he would be damned if he would. In reply, Dr. Worrall said: "It was an absolute falsehood. I was never rung up by Dr. Caro about that patient or any other patient, and I have never answered any doctor in such terms. It is an absolute falsehood." In cross-examination, Mr. Breckenridge sought to gain an admission from Dr. Worrall that, since he could not remember the details of events in his practice as long as 19 years before, he might not be able to remember a conversation with another doctor after the same lapse of time. Dr. Worrall pointed out that an event such as that described would have made an unusual impression on him. He had only heard of Dr. Caro quite recently. It was absurd that he should have had such hostility as to insult him over the telephone.

Dr. Francis Antill Pockley stated that, as far as his knowledge and experience went, the practice did not obtain of a specialist recognizing by a direct or indirect present the sending of patients to him by a general practitioner. In reply to Mr. Breckenridge, he stated that he did not recommend a particular optician, to whom patients could take their prescriptions. His practice was to give a list. Dr. Pockley stated that he had been offered commissions by opticians, and had run them out of the room.

Dr. Joseph Foreman stated that, as far as his own experience and knowledge went, it was certainly not the practice of specialists to reward general practitioners who recommend a patient to him, either directly or indirectly. He had never been approached by an optician or a chemist in connexion with prescriptions that came their way. Asked whether he would be prepared to state that no payment had been made by specialists to country physicians for sending their patients to them, Dr. Foreman replied that he did not know, that he had no reason to believe that it had been done, and that he did not think that any honest man would do it.

Mr. Breckenridge and Mr. Robison addressed the Board. The Board, after holding a consultation, delivered, through the President, the following judgement:—

> Dr. Caro, the Board, after careful deliberation, has found you guilty of infamous conduct in a professional respect, in regard to the first charge, and direct that your name be removed from the register of medical practitioners of New South Wales.
>
> As to the second charge, the Board has not thought it necessary in the circumstances to give a dicision.

Mr. Breckenridge obtained an undertaking, given by Mr. Robison on behalf of the Board of Health, that no action

would be taken if a certain patient, who was extremely ill, were allowed to remain in the hospital for a fortnight. The President intimated that the period would be one fortnight from that day.

Mr. Breckenridge enquired of the Board as to whether, if an appeal were made to the Supreme Court for an expression of opinion on the present case, that would suspend the operation of the decision pending the hearing of the appeal. The President replied that was a matter of law, and that the Board could not answer the question.

TASMANIA.

Joseph Eustace Shelley has been registered as a legally qualified medical practitioner under The Medical Act of 1908.

NEW SOUTH WALES.

The following have been registered under the provisions of the Medical Practitioners Act, 1912-1915, as duly qualified medical practitioners:—

Hunter, John George, M.B., 1915, Univ. Sydney.
Lance, Arnold Llewelyn, M.B., M.S., 1915, Univ. Sydney.

VICTORIA.

The following have been registered under the provisions of the "Medical Act, 1915," as duly qualified medical practitioners:—

Bickart, David, 14 Raglan Street, North Ballarat, M.B. et Ch.B., Melb., 1915.
Brown, Vernon Carlisle, 15 Mercer Road, Malvern, M.B. et Ch.B., Melb., 1915.
De Lacy, Olaf François, 42 Albert Street, East Melbourne, M.B. et Ch.B., Melb., 1915.
Fay, Frank William, "The Hawthorns," Brougham Place, East Kew, M.B. et Ch.B., Melb., 1915.
Jagger, Thomas Ross, Pimpinio (on active service), M.B. et Ch.B., Melb., 1915.
McDonald, Edward, 16 Grattan Street, Carlton, M.B. et Ch.B., Melb., 1915.
Panting, Arthur Ernest, 8 Gordon Street, Toorak, M.B. et Ch.B., Melb., 1915.

Medical Matters in Parliament.

WESTERN AUSTRALIA.

(*Continued from page* 21).

The Legislative Assembly continued on September 9, 1915, the debate on the second reading of the Health Act Amendment Bill.

Mr. George welcomed the Bill, which dealt with the most important social problem that they had to face. This evil was sapping away the youth of both sexes, and was causing incalculable harm. It was menacing family life, and threatening the existence of the human race. It was worse than race suicide, which had taken place, to some degree, in Western Australia. He contended that they could not make people moral either by law or by religion. One of the objects of religion was to inculcate morality, but he asked whether religion had succeeded in this particular case. He desired to go further with the Bill. He would advocate the addition to the Bill of a clause enacting the absolute segregation of the females who were connected with what was called the oldest profession in the world. Since moral influences had failed, since religious influences had failed to stop these practices, since they knew that intercourse had taken place between the sexes for thousands of years, since all attempts to stop it had failed, and since the evil was going on and could not be stopped, let them make the position so that their population should not be infected, and injury done which would go on from generation to generation. He considered that the provision that both sexes should come under the scope of medical supervision was one of the finest steps taken. He supported the clauses dealing with quacks. He would have liked the Bill to deal with abortion and with illegitimacy. Further, he thought a clause should be introduced to provide that no marriage should be contracted unless both parties to it had been examined and proved to be fit to carry on the important functions that they had to perform. He thought that the time would come when the State would not allow marriages to be consummated unless the parties to them could produce proof that they could bring healthy offspring into the world.

Mr. Willmott thought that treatment must be free to be effective. It would cost the State something to stamp out these diseases, but they would get the money back a hundredfold in the extra health that the people would acquire.

Mr. B. J. Stubbs believed that the Bill went too far. In every country where attempts had been made to deal with this question of registration, or with the introduction of compulsion, it had been found to be a failure. Notification was nothing in itself. Nothing was accomplished merely by making returns and compiling statistics, especially if these latter were of questionable accuracy. Notification was a means to an end, the prevention of preventible diseases. Everything depended upon the promptitude with which notifiable cases were "followed up." The disease must be tracked to its lair. Its cause must be discovered and removed. Patients must be watched, and, if desirable, isolated. All this implied an adequate department, well equipped with resources for dealing with the cases notified. It seemed very simple to make the disease notifiable, and then to provide compulsory treatment. In practice it would be found useless for stamping out the disease. What was required was education and free treatment. Night clinics should be established, and the patients should be able to go in secret at any hour for treatment.

The Hon. J. Mitchell said that the Bill was not based on any legislation existing elsewhere. He thought that it should be submitted to a select committee. If ever there was justification for submitting a Bill to a select committee, this was the occasion. He hoped that the Minister would agree to submit the Bill to a select committee. Extensive powers were given in the Bill, and no one could say how they would be used. The Commissioner was given great power, and there was no right of appeal. If the Commissioner had the right to issue a warrant for the detention of any person suffering from the disease, that person should have the right of appeal against the action of the Commissioner. It was obvious that, if such a person desired to appeal, he should have that right even if it meant publicity to his case. Under this Bill the Commissioner had power to detain a person for a certain period, and, if detention was still necessary, all that the Commissioner had to do was to recommend to the Government that the person should be detained further. He asked whether this detention was to last for two years without the right of the individual to appeal. The House would hardly pass that clause without giving the matter serious consideration.

Mr. Mullany believed not only in free treatment, but also in compulsory treatment. If the Government was prepared to provide free treatment there was no reason why men and women who were known to be suffering from the disease, and who refused to accept this free treatment, should be allowed to go free, and be a continual source of infection. After all, it was only when a person was known to be suffering from this disease that the compulsory clauses could be applied. He wished to refer to the attitude of the Friendly Societies in this matter. There was not a Friendly Society in Australia which had not a clause in its rules under which it refused to treat venereal diseases, or to allow persons affected to come under its benefits. Surely a band of men bound together for the mutual benefit of the members, had missed a most important point when it allowed itself to be swayed by a prejudice against persons who had contracted this disease. While there might be some justification for blaming the individual, blame was not going to prevent the spread of the complaint. Whilst the young man or woman were untreated they were a constant source of infection to others. He would recommend his remarks to the consideration of the Friendly Societies. It was objected that the adoption of treatment for these disorders would increase the cost of administration of these societies. He would, however, point out how much the societies would save in the future as the result of the early treatment of venereal diseases. He would recall the re-

marks of the Minister that the medical officers at the Perth Hospital said that 20% of their cases would disappear.

Mr. Thomas was afraid that it was just remotely possible that the Bill would defeat itself by its intricate and technical nature. He could understand how shy the unfortunate individual who had contracted this unmentionable complaint would be about consulting a medical man when he knew that, from the day he stepped inside a surgery his record was left behind him. He would know that his name and address would be taken, and that throughout the term during which he might be suffering, or supposed to be suffering, he would be a sort of ticket-on-leave man at large in Western Australia. He would know that, if at any time the authorities had reasonable grounds for thinking that he had not got rid of all the germs and microbes connected with his complaint he might be apprehended and consigned to a hospital, where he might be kept for two weeks. If he were not free from the complaint in that time he might, on the authority of the Governor, be kept there as long as was necessary. One phase of this particular complaint had been stated by Sir Thomas Fitzgerald to take, at least, two years to cure, possibly a much longer time. He asked whether it was proposed to incarcerate these individuals for two years. These clauses would drive a number of persons into the hands of quacks and individuals, who would treat them secretly. The great defect of the measure, in his opinion, lay in the fact that no provision was made for the prevention of the disease. He would also like to see clauses which would prevent the entry of persons suffering from these diseases into the State. He would apply these clauses to the returned soldiers. He advocated the appointment of a select committee to consider the Bill.

Mr. Griffiths favoured the appointment of a select committee. He was impressed by four considerations. The first was the diminution in the amount of the disease since the repeal of the Contagious Diseases Act. The second was that free treatment and the education of their young people would be a great step towards minimising the effect of the evil. The third was the failure of compulsion, and the fourth the necessity for action. The Bill did not deal with prostitution, but with the subject of venereal diseases and the need for coping with that evil.

Mr. Heitman thought that they must rely on the medical profession for education in connection with this disease, but there must be some great change in the system under which the medical profession worked before the public would receive the benefit of their knowledge. Medical men appointed by local bodies were paid too little for their services. The sums paid were not sufficient to encourage medical men to devote themselves to the prevention of disease. He believed the standard of the medical profession was higher than that of any other profession. It spoke well for them that they found so many of their most brilliant doctors studying the side of medicine which dealt entirely with the prevention of disease.

Mr. Gilchrist supported the proposal to compel all persons suffering from venereal diseases, whether male or female, to submit themselves for medical examination, and to continue to attend the ministrations of a medical man. He would, however, oppose any attempt, whether open or insidious, to endorse the principle of granting clean certificates to prostitutes by which they would be able to advertise their houses, and induce men who would not otherwise face the danger of contracting disease, to go to them. Contaminated prostitutes would be examined under one of the clauses by medical men. When they had been declared clean they would demand a certificate, and it must be granted to them. The prostitute would use that certificate.

Mr. Robinson suggested the appointment of a committee of medical men to report on the Bill.

The Honorary Minister, having replied, the question was put and passed.

The Bill was read a second time.

The Legislative Assembly then sat in Committee. Clauses 1 and 2 were agreed to.

On clause 3, subsections (1) and (2) of the proposed new section 242a, Mr. Thomas pointed out that it was provided that no one, other than a medical man or some person authorized by him, should attend upon those suffering from venereal disease. He wished to insert an amendment into subsection (2) providing that subsection (1) should not apply to a registered pharmacist in the ordinary course of his business. It was possible that the intention might be stretched to an unfair limit to cover many things sold in a chemist's shop. Again, where it was provided that a chemist or any other person, under a permit from the Commissioner, can sell, he objected to "person under a permit in writing from the Commissioner." In a town where a chemist was established he should be the only person to sell these things.

The Hon. R. H. Underwood promised to consult the Attorney-General, and, if an amendment was required, it would be moved in another place. He thought that a chemist could sell things approved by the Commissioner.

New section 242a was put and passed.

New sections 242b to 242h were agreed to.

On section 242i, dealing with compulsory examination and treatment, Mr. Griffith moved an amendment, that in line 4 of subsection (1) after "health" the words "in the country" be inserted, and that after "or" the words "in the town" be inserted.

The Hon. R. H. Underwood opposed the amendment, which was put and negatived.

Mr. B. J. Stubbs moved as an amendment that all the words after "health," in line 4, be struck out. He moved this amendment, as he did not agree with the compulsory examination. This clause could only be intended for use against women of the unfortunate class. The powers were too drastic to be placed in the hands of any person, and they would not aid in eradicating the disease.

Mr. R. H. Underwood said that the clause would be easily worked. Cards would be sent to suspected persons, telling them to call on the doctors. If they were found to be free from infection, what harm would have been done. If they were found to be infected, they would be treated,

Mr. Heitmann regarded the clause with satisfaction, since it would enable the source of infection to be traced. When a number of cases occurred in a town, the number of possibilities could be reduced, and then the source of infection located by examining the suspected persons.

The amendment was put and negatived.

The clause was put and passed.

The proposed new clause 242j was agreed to.

Clause 242k, dealing with subsidized hospitals or salaried medical men to give treatment was considered.

Mr. B. J. Stubbs asked whether it was intended that all persons should be treated free of charge, whether they could pay for treatment or not.

Mr. Underwood said all persons would be treated at the hospitals, and those who could afford to pay could do so. Regulations would be drafted for this purpose. Provision would be made to increase the subsidy of small hospitals if they had to treat many cases.

Mr. B. J. Stubbs moved an amendment that, in line 6, the word "such" be struck out and "all" inserted in lieu, and that, in lines 6 and 7, "or classes of persons" be struck out. The effect of the amendment would be to provide treatment for all persons at subsidized hospitals.

Mr. Underwood agreed with the amendment, but thought that the same result was more easily obtained by regulation.

Mr. Heitmann opposed the free treatment of all persons suffering from venereal diseases, irrespective of whether they could pay for treatment or not. He did not see why sufferers from venereal diseases should be on a different footing from other sufferers in the matter of payment.

The amendment was put and negatived.

The Honorary Minister said that it was intended to raise the subsidy to medical men who had to treat these matters.

The proposed new clause was put and passed.

On proposed new section 242l, dealing with advertisements, Mr. Smith said that he thought that the provision, which referred to the publishing of any statement intended to promote the sale of any article as a medicine, etc., for the cure of diseases, covered diseases which were not contemplated by the measure. This clause would have the effect of preventing the sale of legitimate medicines for the cure of diseases other than venereal diseases. He therefore moved an amendment that the words "or disease

affecting the generative organs or functions or of sexual impotence or of any complaint or infirmity arising from or relating to sexual intercourse or of female or menstrual irregularities" be struck out.

The Hon. R. H. Underwood opposed the amendment. The difficulty was that these alleged remedies were interwoven. The Bill had been drafted so that it would not miss anything. It might include something that did not apply to venereal diseases, but he thought that it would be better to leave in the words.

The amendment was put and negatived.

Mr. George moved an amendment that, in subsection 2, the following be added, to stand as paragraph (g), "sends to any persons through the post or by any delivery any printed or written matter referring to and recommending the use of alleged remedies for venereal disease."

On the Honorary Minister undertaking to refer the proposed amendment to the Crown Solicitor, the amendment was withdrawn by leave.

The proposed new section was put and passed.

The proposed new section 242m was agreed to.

The clause was put and passed. Clauses 4 and 5 were agreed to.

The title was agreed to.

The Bill was reported without amendment, and the report adopted.

On September 14, 1915, the Bill was read a third time, and transmitted to the Legislative Council.

(To be continued.)

Special Correspondence.

(From Our Special Correspondent.)

CANADA LETTER.

The New Session.

The universities have commenced another session with their staffs much reduced, since so many members of the teaching staff in every faculty are on active service. In the medical schools this is particularly true, for the Universities of McGill, Toronto, Queen's, Dalhousie, and Laval have each contributed a military hospital for service overseas. The number of students is also rather less than in previous years, as so many young men have gone to the war. The University of Alberta is now able to give instruction in the first three years in medicine; last year only the first and second years were given. Arrangements have also been made with the Universities of McGill and Toronto, whereby students who have taken the first three years of the medical curriculum at the University of Alberta can enter these universities for the fourth and fifth year of the course without further examination. At the University of Manitoba the freshman year is small, owing partly to the effect of the war but chiefly to the new arrangement which requires a student to take one year in science before entering upon the study of medicine. The Institute of Public Health at London, Ontario, which is the Public Health Department of Western University, is offering a postgraduate course in public health, consisting of a winter session of eight months, followed by a summer course of three months, during which time candidates act as assistants to the London Board of Health in its various departments. The Director of the Institute, Dr. W. H. Hill, is also Medical Officer of Health of the city, so that those taking the course will have unusual opportunities of gaining experience in every branch of public health work. At Dalhousie University, Halifax, Nova Scotia, the faculties of arts and science have been moved to a new building, and the medical school now enjoys ample accommodation.

McGill University recently conferred the honorary degree of LL.D. upon His Majesty the King of the Belgians "as a slight expression of the great admiration felt throughout Canada for the heroic courage and devotion with which he had led the people of Belgium in their resistance to an altogether unjustifiable, but evidently long premeditated attack on the integrity and independence of their country."

The Military Hospitals.

The McGill General Hospital, No. 3, is stationed at Camiers, near Boulogne, France, where it has been in operation since August 10, 1915. With the exception of the operating building, it is at present under canvas. The hospital tents were supplied by the British Government, owing to delay in the delivery of the Canadian ordnance; these Durbar tents were presented to the War Office by Indian magnates, and are most spacious and luxurious. During the winter huts will be provided for patients who are seriously ill, and for the nurses; officers and men will remain under canvas.

No. 5 Stationary Hospital (Queen's University) is now at Cairo, Egypt, and Stationary Hospitals Nos. 1 and 3 are stationed on the Island of Lemnos, in the Aegean Sea. Lieutenant-Colonel Hanford McKee, of Montreal, who was in command of No. 1 Stationery Hospital, has been seriously ill and invalided to England. The commanding officer of No. 3, Colonel Casgrain, of Windsor, Ontario, is also reported to be seriously ill at Alexandria, and the unit is now in command of Dr. O. A. Cannon, of Stratford, Ontario. No. 4 Stationary Hospital (French-Canadian), under Colonel Mignault, of Montreal, is under canvas near Paris; it has been given to France by Canada for the treatment of French wounded, and is equipped to accommodate five hundred patients. No. 6 Stationary Hospital, the contribution of Laval University, is under the command of Lieutenant-Colonel George Beauchamp. The unit is up to full strength, and it is expected will sail for England early in November.

No. 5 General Hospital was recruited in the province of British Columbia, and is at present in England. It is under the command of Lieutenant-Colonel E. C. Hart, of Victoria, and numbers among the members of its staff many well-known members of the profession. An appeal for funds was made throughout the province of British Columbia, and was so generously responded to that over $33,000 was subscribed, whereas the amount actually required was $25,000.

The Saskatchewan Stationary Hospital, the gift of the Medical Association of Saskatchewan, is in process of organization, as is the hospital offered by Dalhousie University. The latter will probably go to Egypt.

An appeal for contributions to the British Red Cross is now being made throughout the Dominion. The arrangements are in the hands of the municipal authorities. In Ottawa alone over $40,000 was collected on Trafalgar Day, and collections made in Toronto amounted to $500,000. An appeal will be made in Montreal on October 28, 1915.

Hypodermic Units of Morphine.

In response to an appeal made by Captain James C. Fyshe, C.A.M.C., who is with the First Field Ambulance of the Canadian Expeditionary Forces, thousands of hypodermic units, each containing ¼ grain morphine and $^1/_{150}$ grain atropine have been sent to England to be forwarded to Regimental Aid Posts and Field Ambulances for use in emergency cases. The practice of placing a tablet of morphine beneath the tongue has not proved satisfactory, and, as was pointed out by Captain Fyshe, there is no time during an action to make up hypodermic solutions. These "units" have been found to be of great service at the front; they are complete in themselves and are easily administered.

The Late Professor A. W. H. Lindsay.

The death of Professor Andrew W. H. Lindsay from heart failure occurred at Halifax on July 21, 1915, during a meeting of the Nova Scotia Medical Board, of which Dr. Lindsay has been the registrar for over thirty years. Dr. Lindsay occupied the Chair of Anatomy at Dalhousie University. He had been closely connected with the Medical School, and its strong supporter before and after it was incorporated into the University, and no one has done more for medical education in the province of Nova Scotia than he. Moreover, he was a brilliant teacher of anatomy, with a profound knowledge of his subject. Born at Pictou, Nova Scotia, in 1851, Andrew Lindsay was educated at the Pictou Academy and at Dalhousie University, where he obtained the degree of Bachelor of Arts in his nineteenth year. In 1875 he graduated in medicine, and, entering the University of Edinburgh, in one *annus medicus* passed the

three examinations required, and graduated M.B., C.M., in 1877. On his return to Halifax he became associated with the Halifax Medical College, which later was incorporated into the University.

Correspondence.

A SCHEME OF UNIVERSAL MEDICAL SERVICE.

Sir,—It has fallen to the lot of the writer during the last few months to get in touch with the medical profession in England, in the Mediterranean, and in Australia; and a unique opportunity has presented itself of acquiring an unbiassed view of our relationship to the great war and our attitude towards it.

The outstanding impression, common to the whole of the members of the Army Medical Corps, Australian Imperial Forces, both at home and abroad, is that of muddle and consequent discontent, amounting in some instances to absolute despair. That there is cause for this impression, anyone who has had an opportunity of viewing the actual conditions, will at once admit, but that the position is without remedy is an opinion that must not be entertained for a moment. There is no reason why we should not apply the same methods to the solving of this problem, as have been applied to the solving of the problems of our everyday work, and ask (1) What is the cause, and (2) What is the remedy? The following is an attempt to show that there is an answer to both these questions.

The days of hysterical flag-waving and jingoism are over; we are now in the second year of the coldest, scientific war on record. We are a profession of scientists, and as such should be as capable of dealing scientifically with the disorders of the nation as with those of the human body.

The four classes of patients that come under the care of our profession are:—

(1) The sick and wounded at the front.
(2) Those on the lines of communication.
(3) Those at the base.
(4) And last, but by no means least, the civil population of Australia.

With the system that we have adopted up to the present, these duties have been performed by a loyal few who have answered their country's call without hesitation. Australia has reason to be proud of the work of these few, but it must be evident to everyone that a system of this kind cannot stand an unlimited strain, and this particular system is dangerously near the breaking point now.

At the outbreak of the war, the majority of the profession, who belonged to the Australian Army Medical Corps, volunteered at once, and joined the Expeditionary Forces. These were the men who were ready, who had given up their Saturday afternoon golf and their spare evenings to be ready when the call came. Next to follow were those who, though unversed in military matters, felt the call of duty in gradually diminishing degrees, until, by the end of the war, only the unfit and the slackers will remain to be accused (and rightly so in many instances) of fattening on the sacrifices made by their loyal colleagues. The time has come when this state of affairs must be altered. Every medical man in Australia is needed, so that the work which is now falling so heavily on the few may be borne lightly by the many. It is faith in this great uncalled, unorganized reserve of men that gives me faith in our ultimate victory over a foe that has been organized for over forty years. If we have held them so long with our notoriously muddling methods, what can we not do if we are organized?

What are the causes that are preventing our profession from enlisting more freely?

(1) After enlisting, the notice given by the military authorities is often so embarrassingly short; in some cases only twenty-four hours.

(2) The fear that the want of previous military training will stand in their light.

(3) The statement that many of our leading men who have already enlisted are idle, both in England and in the Mediterranean.

(4) The feeling that their professional inferiors have been given high military rank, and they might have to serve under them.

(5) The inability to stand the financial strain.

(6) The fear that someone will grab their work in their absence.

To deal with these *seriatim*:—

(1) The short notice given by the military authorities.—Of necessity, the authorities cannot be aware of every man's position, and know the extent of his sacrifices. This is for the B.M.A. to deal with, as I shall show later on.

(2) The want of previous military training.—In peace time many of us looked down on the man who "swanked around in uniform." We did not realize the sacrifice he was making, nor the forethought that prompted the sacrifice. The average man is quite ignorant of the A B C of military methods. Speaking personally, I was hurled from civilian life into the position of having to appear on parade on a troopship alongside a unit of our regular forces. Never in my life have I felt so foolish or so ignorant. I had no idea of the difference between a nominal roll and a fatigue party. I knew neither how to salute nor when to salute. By hard experience I now know enough to avoid elementary mistakes. Much has been forgiven me. One month's training in the evening by a military instructor would give every medical man enough knowledge to "carry on" his duties as a military officer. Schools for this purpose could be formed and organized by the local Branches of the B.M.A. The Defence Department would, I am sure, supply the instructor.

(3) The statement that many medical men are idle at the hospitals in the war area.—This is only a half truth, and therefore worse than a lie, but it is the impression that most men get before they understand the working of things. On arriving in England, I felt that the sooner I got back to Australia and congenial work the better; now I have realized that a military organization must be worked out on a maximum, and not a minimum basis, so that when the extraordinary call comes, it may not collapse. The whole history of the war shows big actions, alternating with periods of comparative inaction. During the latter, it is obvious that some men must of necessity be idle; but it is in their presence, in their readiness for emergency, that their military strength lies. The one great lesson that must be learned by the untrained A.M.C. man is that every man must be ready to do any duty of a medical nature that the requirements of the service demand. If an opportunity arises for him to use his special gifts of training, such as that of surgeon or physician, so much the better; let him seize it. But if there is not that work, he must do uncomplainingly the ordinary work of military routine. If every specialty is to be attended by a special man, the supply of medical men will soon run out. There is a story, current throughout the whole of Australia, of a famous Melbourne surgeon being put to attend measles. The facts, I believe, are these: During a severe epidemic of this disease among our troops, when surgical work was slack, this famous surgeon volunteered to take his turn as physician; he was a big enough man to sink his surgical dignity and share the duties of his overworked physician brethren. Let every man take a lesson from this great leader of our profession.

(4) The fear that one's professional inferiors may occupy a higher military position.—This is bound to happen in a few isolated cases. Speaking from experience, one of the hardest lessons for a medical man to learn when he joins the army is obedience to a superior officer. We are naturally independent, and our training developes that independence. As soon, however, as one realizes that the authority is exercised in military matters only, the irksome feeling disappears. Sufficient freedom of thought and action is left to give scope to our individuality. If the position is untenable, it is always possible to transfer to another unit. In any case, matters soon right themselves; the incompetent man is soon removed to a position more suited to him; and in a game of this sort, what matters it whether a man is a captain or a colonel, so long as he serves his country: the rank does not make the man.

(5) The inability to stand the financial strain, and (6) (ugliest of all) the fear that someone will grab their work in their absence.—These two are the real causes of our not enlisting, and it is of these two and their remedy that I wish particularly to speak. The one lesson of this war has been that nothing effectual can be accomplished with-

out organization. Our enemy knew this forty years ago; we have only just realized it, and have had to begin at the beginning. Like the rest of the nation, the medical profession must be organized, but, fortunately for them, they have not to begin at the beginning; they have one of the best organizations in the world ready to their hand in the B.M.A. As a councillor of this body for the past eight years, and vice-president for the past year, I am intimately acquainted with its ramifications in New South Wales. And what is true of New South Wales is probably true of the rest of Australia. The profession in this State is the largest individual Branch of the B.M.A., and has on its rolls over 90% of the medical men who are in practice. It is one of the best organized bodies in the whole of the English-speaking world.

The central body, the Council of the B.M.A., which consists of the tried and trusted representatives of the profession, must act in conjunction with the local associations. They must have full knowledge of every man's circumstances; his name, his age, date of graduation, post-graduate experience and training, result of medical examination for physical fitness by one who must sign a declaration that the examinee is not a relative or intimate friend; his last year's income, and average income taken over the past three years, if such a time has elapsed since his graduation; number of dependants and ages of children, if any; his personal wishes as to the nature of his military service.

With these particulars at hand, the profession could deal scientifically with any military emergency they were asked to meet, with the care of the troops on the one hand, and the care of the civil population on the other. With a limited number of medical men to do the work, it is a simple matter of calculation to work out what proportion of men must be allotted to each. Any requests from the Defence Department for extra men or men to relieve those who are at the front could be met without the slighest difficulty. Those physically unfit, either from age or from bodily ailments, must do some duty at home, and so fulfil their obligations. Those unable to help by work must do so financially.

The central body most able to deal with the allocation of duties would be (1) the Council of the B.M.A., or (2) a sub-committee of that Council, or (3) that sub-committee, supplemented by representatives of the profession, to be elected at an extraordinary general meeting convened to go into the whole scheme.

The one thing absolutely essential is that every man should lay his cards openly on the table. To guard against an infringement of this rule, a penal clause must be enforced against any man making a false declaration, the penalty being, say, up to twelve months' extra service.

The great point is that we should trust one another.

In regard to the fear that someone would grab the medical officer's work during his absence, it must be remembered that this game is being played for too high a stake, that of our very national existence, and the sooner we realize this the better. Every man must come into line. Men in the twenties are urgently needed for the Expeditionary Forces, men in the thirties are needed too, men of forty-five and over are not needed, unless specially qualified to be of service to the troops, or unless sent to replace someone who returns. Before Australia has done her duty, she will have to have sent at least 400,000 troops to the front; it is impossible that the medical men already at the front can cope with these additional numbers. Many of those who gave their services at the beginning are worn out now, and others of the same standing must be sent to relieve them, to let them return for a well-earned rest, and give them an opportunity of gathering together again the threads of their scattered practices. Before the war is over the whole profession will be a trained army medical service, ready for any emergency, and able to hand on their training to the next generation.

The Defence Department has been communicated with, and they are quite willing that the B.M.A. should take over the management of this matter, namely, the supply of medical officers, if it proves able to do so. What body of men with any claim to commonsense would refuse the assistance of an organization as complete as that of the B.M.A. Even un-organized as we are now, splendid work has been done at the front and at the base hospitals. Australia has no need to be ashamed of her medical men. But why should these few loyal men struggle along with their one-horse dray when the fifty horsepower motor-lorry of the B.M.A. is waiting ready for use. All that is needed is someone to start the engine.

Yours, etc.,
GORDON CRAIG, Lt.-Col., A.M.C., A.I.F.

Sydney, January 1, 1916.

ORTHOPÆDICS AND THE WAR.

Sir,—The fact that a special unit has been sent from Australia to deal with venereal disease amongst our troops at the front brings up the question as to whether there should not be a further application of this principle of specialism in military surgery at the present time.

To anyone who has had an oportunity of examining numbers of returned wounded, it is evident that a considerable proportion of the cases consists of men who have suffered from gunshot wounds of the limb bones, with accompanying lesions of muscle and nerve. Military necessity has prevented the medical officers giving to these men the detailed attention which is advisable if the function of the limb is to be saved to any great extent, and they return to Australia with limbs likely to be permanently impaired in function, to be a charge on the Commonwealth for the rest of their lives.

This condition of affairs might be greatly improved if special hospital ships were sent to the scene of action, in charge of surgeons who take special interest in orthopædic work. The surgical staffs of these ships, before being allotted to them, might undergo, say, a three months' post-graduate training at our Universities, in the anatomy, physiology, pathology and surgery of bone, muscle and nerve.

Experts in the education of muscles should be trained. Masseurs and masseuses should be provided in greater numbers, together with the necessary equipment.

When the patients reach Australia, similar hospitals or departments in existing hospitals, could be utilized, with the staffs thereof, to carry on the good work. Surely we have and can train in Australia the men and women for this specialty.

The work of Robert Jones, in England, gives us an example which, if followed, would save, over and over again, to the Commonwealth in pensions alone the cost of the personnel and equipment. Why delay longer? Why not "Do it now"?

Yours, etc.,
"AVIATOR."

Obituary.

JOSEPH DAVID BUCHANAN.

The death of Dr. Joseph David Buchanan, announced in last week's issue, is another of those calamities which are filling the whole world with gloom and sorrow.

He was born in Brisbane in the year 1879. His parents were well known in the capital city of Queensland, and his one brother has attained prominence in municipal politics. His general education was conducted at the Christian Brothers' College, in Gregory Terrace, from which school he passed into the Sydney University. His student days were characterized by his popularity and excellent work and excellent play. He graduated in 1905. Returning to his native city, he was appointed a Resident Medical Officer at the General Hospital Brisbane, and, after a year's service, he undertook work at Goodna for a further year. In 1907 he paid a visit to the old country, and then settled down in practice, first in Wickham Terrace, and a few months later in Ann Street, Valley, in 1909.

Toward the end of 1914, he recognized the urgency of the country's claims on the members of the medical profession, and volunteered for service with the Australian troops. He left Brisbane in December, 1914, with the 2nd Australian Expeditionary Force, in company with the Field Ambulance. After passing through Egypt, he was detailed for duty in the trenches in Gallipoli. He remained in the trenches at Anzac for four or five months, in charge of the 2nd Australian Field Ambulance. Toward the end of this period,

he contracted dysentery, like so many of the men with the colours. When no longer capable of carrying out his duties, he was sent back to the No. 1 Australian General Hospital at Heliopolis, and placed under the care of Major J. B. McLean. On his recovery, he was transferred to the Base Hospital, but no sooner had he returned to duty than he was seized with a relapse. A cable has announced his untimely death, presumably during the relapse.

Joseph David Buchanan was an extremely popular man, both with his colleagues and with his patients, acquaintances and friends. He possessed marked social gifts, which attracted to him many men and women in various spheres of life. He was skilled in the practice of his profession, and was always keen and conscientious. Within the ranks of the Queensland Branch of the British Medical Association, he worked assiduously, and his counsels were always listened to with attention. He became a member of the Council, and when he left for the front was Treasurer. And now his old friends on the Council, his colleagues in the profession, his patients, and many, many others mourn the loss of a man worthy of the name.

Medical Appointments.

Dr. R. E. Kane has been appointed Government Medical Officer of Health at Catherine Hill Bay, New South Wales.

Dr. F. C. Higgins has been created an "Appointed Member" of the Licensing District of Penrith, New South Wales, during the absence of Mr. W. H. A. Pye.

Dr. J. W. Morgan has been appointed Officer of Health for the North and Central Ridings of the Karkarooc Shire, Victoria, in place of Dr. Jas. Gregg (resigned).

Dr. H. S. Bourke has been appointed Officer of Health for the Centre and West Ridings of the Kowree Shire, Victoria, in place of Dr. R. O. Burnard.

Dr. Clive Shields has been appointed Officer of Health for the East Riding of the Hampden Shire, Victoria, during the absence on military duty of Dr. J. G. Desailly.

Dr. W. W. S. Jones has been appointed Officer of Health for Phillip Island Riding of the Phillip Island and Woolamai Shire, Victoria, in place of Dr. Chas. Lethbridge (resigned).

Dr. F. W. Green has been appointed Officer of Health for the Poowong and Jeetho Shire, Victoria, in place of Dr. Cave (resigned).

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xiii.

Public Service Board, N.S.W., Medical Officers, Ophthalmic Surgeon, Throat Surgeon, Dentists and Nurses.

Proserpine District Hospital, North Queensland, Medical Officer.

Oberon District, Resident Doctor.

Children's Hospital, Perth, Chief Resident Medical Officer.

Bendigo Gold District General Hospital, Junior Resident Medical Officer.

The Medical Politics Committee of the Council of the New South Wales Branch, at a meeting held on January 4, 1916, requested that members should be advised not to apply for the positions as Medical Officers, etc., Department of Public Instruction, as advertised in *The Medical Journal of Australia*, pending an Extraordinary Meeting of the Branch, convened for 8.15 p.m., on Friday, January 14, 1916, to consider the whole question.

Diary for the Month.

Jan. 11.—N.S.W. Branch, B.M.A., Council (Quarterly).
Jan. 13.—Vic. Branch, B.M.A., Council.
Jan. 15.—Northern Suburbs Medical Association, N.S.W.
Jan. 18.—N.S.W. Branch, B.M.A., Executive and Finance Committee, Ethics Committee.
Jan. 19.—West Aust. Branch, B.M.A., General.
Jan. 19.—Northern District Medical Association, N.S.W., Armidale.
Jan. 21.—Central Southern Medical Association, Goulburn.
Jan. 21.—Queensland Branch, B.M.A., Council.
Jan. 25.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
Jan. 26.—Vic. Branch, B.M.A., Council.
Feb. 2.—Vic. Branch, B.M.A., General.
Feb. 4.—Queensland Branch, B.M.A., General.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. Croydon Hospital.
WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Arncliffe F.S. Lodges. Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Mullumbimby District Friendly Societies. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Litngow. F.S. Lodges at Mudgee, (except A.H.C.G. & M.U.I.O.O.F.) F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith. and Auburn. F.S. Lodges at Wellington. Newcastle Collieries— Killingworth. Seaham Nos. 1 and 2. West Wallsend.
SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.